*The American Journal of*
# NURSING

Volume XXIX JULY, 1929 Number 7

## Advancement of Education through Legislation [1]

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THE National League of Nursing Education, the oldest organization of all assembled here, is concerned primarily with the great problem of the education of nurses, in the preparation of women first of all in the knowledges, skills, technics and qualities needed by everyone who is to give good nursing care and secondly in the further preparation required by those who would enter special forms of nursing service which require special technics and special knowledges. We are interested in the development of the nurse in service, in making possible for her the advantages of higher education, we are interested in research and we are interested in the field into which our young graduates enter.

Our object is to determine and to make possible the best education for the workers. We know if we are to do this we must know the field. We must acknowledge that the sole interest of a school of nursing must be the education of its students. It is here that we are sometimes misinterpreted, for our schools are so closely tied to our hospitals, our students are so needed by the hospitals for the care of patients, that to some this statement may seem selfish. Not so if we analyze the situation. We covet proper conditions, good education for our students, both in basic courses and later. We want the best prepared nurse possible—for what purpose? Is it that the nurse may personally benefit from a satisfactory education? Incidentally she may do so, but our whole object is better nursing service of all types for those who need such service.

No group is more interested in the actual nursing service of the hospital than those who are members of the League. As individuals and as an organization, we are continually torn by our interest and responsibility for the nursing service of our hospitals. Our best teaching is done at the bedside of the patient. An efficient and skilled nursing service is a necessity to a good school of nursing, and no such service can be attained where a school is located unless the teaching of students who give a great share of the care to patients is what it should be.

The exhibit which you will all see among the educational exhibits attempts to show the demands made upon nurses through the growth of knowledge in bacteriology, chemistry, physiology and other sciences and the teaching made necessary through the advancement of medicine.

[1] The President's Response to Address of Welcome and Address at the Opening Session of the Thirty-fifth Annual Convention of the National League of Nursing Education, Atlantic City, N. J., June 17, 1929.

It was pioneering, fifty years ago, to clean up those old wards and introduce new ideas and ways and to begin the training of nurses. Every stage in development has called for workers with the spirit of the pioneer and pioneering is not at an end. I am of the opinion that our situation today is almost more difficult than it was in the early days, for it is simpler to see and overcome the obvious than to move forward after a certain degree of excellence and satisfaction is attained.

Today we have problems which were never dreamed of in the earlier days, and which were not problems to us ten years ago, although many of the old ones are, as well, still with us. Never again will it be as simple to conduct a school, to set up a curriculum, to teach what should be taught, and at the same time provide good nursing care for the patient as it was in "the good old days." In the good old days, the diets were regular, soft or fluid, research was unknown, complicated treatments had not been devised, cures were effected through drugs, rounds occurred at regular intervals, the world was devoted to working twelve hours a day, and the health of workers was not considered. Young women were more mature when entering our schools and the majority came with home training of a definite helpful type, automobiles were not built and women did not smoke. We had no particular concern if a student who liked the operating room service remained there for eight or ten months and missed her dietetics and children's training in consequence.

During the past month most of us here have been seriously studying our own schools. We have spent long hours and days, especially if the school has been large, in checking up the experience and the teaching which we give our students, and we are doing it as a first step toward the grading of the schools in this country. Shortly, I presume, we will each be told how our school compares with others in many respects. I suspect that to many this process of examining our work has been somewhat discouraging for the reason that when we study critically a piece of work we are attempting to do, we see the defects and the largeness of our problems overshadowing our accomplishments. It is never easy to take stock, but it is a very sound way to start constructive work.

Just how the grading will proceed I presume will depend on the developments of the next few months. It is not my intention to discuss the grading of schools, or the program of that committee. I wish, however, to bring forward one phase of our present situation which is involved in the grading of schools and in which I believe this organization should have great concern. I refer to the laws which govern the practice of nursing. Perhaps your reaction to this statement may be that legislation is the concern of the American Nurses' Association and not that of the National League of Nursing Education. Yet we find that at the third annual convention of the Society, at its meeting in Philadelphia, in 1896, Miss M. E. P. Davis, the president at that time, stated as the Association's first and main object "furthering the best interests of the nursing profession by establishing and maintaining a universal standard of training."[1] She further said, speaking of the 221 schools then in existence in Canada and in the United States, "Until the qualifications, examinations and percentage of excellence are

[1] Third Annual Report, American Society of Superintendents of Training Schools for Nurses.

the same (referring to all types of schools) we can have no uniform curriculum or universal standard of training."

At the fourth annual meeting, Mrs. Hunter Robb presented a paper which was an exposition of the evils arising and in existence from the establishment of so-called schools of nursing in hospitals unable to give a proper course of training, and a condemnation of the practice of the hospital which opens a school distinctly for its own gain, and the sending out from such hospitals of the student nurse to earn for the institution under the lure of "honor" and the diploma.

In the discussion of this paper it was clearly shown that the diploma must be made to mean more than it did at the time, and that there should be a way to distinguish between such documents. Here Miss Dock drove in her point by stating, "That can be effected by a national association working through state societies to secure state laws." Again, at the seventh annual meeting, in 1900, the increasing need for protection was emphasized when it became necessary for a memorial to be drawn up and sent to the College of Physicians of Philadelphia and to the Philadelphia County Medical Society protesting against the action of 304 members of the College of Physicians of Philadelphia lending their names to a project under the name of the Philadelphia Nurse Supply Association which had as its object the education of women as nurses during a course of but ten weeks' duration. At that meeting Mrs. Robb stated, "The only way to distinguish between such graduates of bogus institutions and graduates from good training schools is to have legalized registration."

I do not intend to go on delving into our history, or to outline the beginnings and progress of state registration as it later developed through the formation of the Associated Alumnae and the state societies. I merely wish to remind you that the League in its very early days saw that the way of setting up standards and especially of maintaining them was by the way of legislation.

As individuals, and as members of state nursing associations, we have all undoubtedly taken part in efforts to secure good laws. This matter of our laws should, however, come before us as a body, for while twenty-five years (a quarter of a century) has elapsed since the first laws governing the practice of nursing were obtained in this country, certain requirements now set forth in these laws are of as low a grade as they were at that time. You will now enquire, "But will not the grading plan tend to standardize?" and I will say that it undoubtedly will, but of itself it will do little. Following grading, there must be regrading and the setting up of progressive standards.

The standards of nursing care and of education of the nurse as shown in the old Bellevue wards are not accepted today. Our legal standards of nursing of 1903 should not be those of 1929, nor should those of 1929 be unchanged in 1940–50. Education must raise the standards to meet the changing needs, public opinion will demand better nurses and nursing legislation must be obtained which will help maintain them.

It will be in the future as at present the particular work of the various state nurses' associations to secure amendments to the laws, but the state leagues and the National League must, with a united front, demand as high standards as can be obtained. No group is more interested in the amount and character of the general education

which is demanded of entering students and who later swell the ranks of our graduates than is the League. The laws controlling nursing practice presumably voice our ideas of what the minimum professional education should be which can fittingly prepare women as nurses. However, if one were to judge by these laws it would appear that the needs of the sick must vary in accordance with the state in which they live.

In eight states, a girl who has completed eight grades of the elementary school is considered to have sufficient general education to enter a school of nursing; in twenty-one states, she must have had one year of high school; in eleven states, two years of high school; and in five states, four years of high school; while in four states, the matter of education is left to the decision of the Board of Nurse Examiners.

We are naturally much interested in the personnel of these boards of nurse examiners. This is the group which, in the majority of states, set up the standards of training, for it is they or their representatives who inspect the schools, who actually determine what shall be an accredited school, who set the examinations and rate the candidates for the license to practice. An examination of the laws gives us the following information:

In 28 states, the Board is composed wholly of nurses.

In 11 states, the majority of the members are nurses; the other members are physicians.

In 5 states, the majority of the members are physicians and the others are nurses.

In 1 state, the Board is composed wholly of physicians.

In 1 state, the Board is made up of nurses and one lay member.

The manner of appointment of the members of these boards is of interest as well. We find again by a study of the laws that

In 24 states, they are appointed by the Governor or other state official or agency on the recommendation of the State Nurses' Association.

In 12 states, they are appointed by the Governor without such recommendation.

In 1 state, the Governor appoints with the advice of the Council.

In 2 states, the Governor appoints with the advice of the Senate.

In 2 states, the State Board of Health appoints without prescribed advice.

In the District of Columbia the Commissioner of the District appoints.

The professional qualifications of the nurses on these boards, as prescribed by law, range from the simple qualification that they shall be graduate nurses, to the requirement that they shall have had five years of educational work with nurses. In Wisconsin it is prescribed that there be representatives on the Board from the three major fields of nursing. The situation is as follows:

19 states require that members of the Board be graduate nurses.

20 states require that members be graduates of schools accredited in the state in which they were graduated.

8 states require that members should have had experience in educational work with nurses.

12 states require that members be actively engaged in nursing immediately preceding appointment.

3 states require that members shall not be connected with a nursing school.

4 states require that members be graduates of different training schools.

25 states require a number of years' experience since graduation.

One cannot help wondering what a study of the qualifications of the individual members of these boards of nurse examiners would reveal. Under such meager legal provisions, what qualifications, both professional and personal, do we accept for these important representatives? We certainly would agree that physicians have no place on our boards of nurse examiners, but since they are members

in seventeen states, a study of their qualifications would also be enlightening.

We are tremendously concerned with the amount and character of the clinical material we provide for our students, but what we ask for in our laws is indicated by the bed capacity of the hospitals, and also the daily average number of patients accepted.

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|---|---|---|---|---|
| In 19 states | there is no statement. | | | |
| " 2 " | the requirement | is 20 | beds. | |
| " 12 " | " | " | " 25 | " |
| " 5 " | " | " | " 30 | " |
| " 4 " | " | " | " 35 | " |
| " 2 " | " | " | " 40 | " |
| " 3 " | " | " | " 50 | " |
| " 1 " | " | " | " 75 | " |

The daily average number of patients required is as follows:

| | | | |
|---|---|---|---|
| In 1 state | eleven (11) | patients. | |
| " 2 " | twelve (12) | " | |
| " 6 " | fifteen (15) | " | |
| " 1 " | eighteen (18) | " | |
| " 7 " | twenty (20) | " | |
| " 6 " | twenty-five (25) | " | |
| " 6 " | thirty (30) | " | |
| " 1 " | thirty-five (35) | " | |
| " 1 " | forty (40) | " | |
| " 1 " | fifty (50) | " | |

In certain of the states, no provision is made even for the smallest schools, either in the laws or by the boards, for required affiliations. As a matter of fact the Red Cross has done quite as much, if not more, to stimulate some of the schools which may operate legally as accredited schools, while providing a clinical service of only twelve, fifteen or eighteen patients, to increase this service through affiliation.

Another curious and very important matter to which we appear to have given little consideration is that of the length of time it should take to give this minimum education which the laws must always represent. Twenty-six states appear to realize that the minimum curriculum outlined should be given in a minimum time, for twenty-two states set this minimum time at two years, and four states at two years and four months.

But twenty-five states outline their minimum curricula and require that the students remain in the school the maximum time. In fact, some laws require *three years in a hospital* which makes it impossible to add public health experience or to give credit for college work.

Under this three-year requirement we find that a school connected with a hospital which has a daily average of but twelve to fifteen patients and which is accredited, is required by the law to keep its students three years. Are we not penalising and exploiting the student when we accept such conditions? If the education prescribed by the law is minimum, the length of time in which it is given should be minimum.

These are examples, only, of the situation. The fact that we have no law which requires all those who nurse for hire to be licensed adds to our difficulties. Anyone, anywhere, may care for the sick so long as they do not practice under certain prescribed titles.

We have taken no definite steps toward a national examining board such as the American Medical Association took in 1915. Such a Board would not only assist to clarify the standards of nursing education in this country and help solve the reciprocity question, but would also be a first step toward reciprocal relations with other countries. Have you not been astonished, in reading the hospital statistics published by the Council on Medical Education and Hospitals of the American Medical Association, to discover how many hospitals are conducting schools which are not even accredited under these minimum laws?

There are splendid schools of nursing in this country. The Grading Committee is going to be proud, indeed, of many of them, but is it strange under these conditions that certain educators do not see why the National League of Nursing Education questions the advisability of the acceptance of Smith-Hughes funds which are intended to aid schools on a secondary level?

Is the matter of legislation one solely for the American Nurses' Association to solve? Is it not one of the great problems in nursing education in which the American Nurses' Association, the National Organization for Public Health Nursing and the National League of Nursing Education should join forces in a constructive program for elevation of standards in the states, for compulsory licensing and for a national examining board?

# Malignancy

## *The Nursing Care of Patients with Malignant Conditions*

IRA I. KAPLAN, M.D

IN caring for the many thousands of patients who come to Bellevue for relief, the nurse plays not only an important but indeed a most essential part. No modern hospital could possibly function without her, and of course her training enables her also to carry on the work of aiding the sick outside the hospital as well.

Since the days of Florence Nightingale, that early apostle of humane care of the sick, there have been many changes in the sphere of nursing, just as there have come many revolutionary advances in the science of medicine, and the trained nurse has found it necessary to keep abreast of all these changes in order to maintain and increase her usefulness and service to the doctor and patient. With each advance in the progress of medicine and surgery there has come a constantly greater demand for the specially trained and enlightened nurse to make effective use of the new knowledge and procedure.

Particularly in connection with the problem of the hopeless and chronic cases have efforts been directed towards amelioration, and these efforts have received a new impetus with the discovery of the newer aids to medicine and surgery. Among such aids none are more radical or spectacular than the radiant rays of the x-rays, radium and the high frequency current. Patients who receive treatment with these agents require, in addition to the usual nursing care afforded the sick, some specialised attention due to the condition of the disease and the method of therapy employed.

This is especially so when the patient is suffering from cancer. Years ago, a diagnosis of cancer was regarded as a signal of inevitable doom for the sufferer, and for that reason only the least intelligent, least able and least trained person was assigned to care for him. It is not to be wondered at, therefore, that just the word "cancer" carried with it such fearful significance and produced in the patient a dreadful mental reaction. Nowadays, however, we know we can do a great deal for the cancer patient and in

conjunction with a well-informed, efficient nurse, the specialist is not unwarranted in offering more than a little hope.

There is no question but that the nursing care of the patient suffering from malignant disease is indeed a serious problem. The nurse, herself, needs to be unusually intelligent, possessing among other things a working knowledge of dietetics. She must be tactful, patient, ingenious, resourceful, pleasant-mannered, willing, and having a goodly portion of that virtue denominated by the Yankees as stick-to-it-iveness to enable her to stay on the case despite the loathsomeness of the disease and the almost intolerable ill-nature of the patient.

Patients with malignant lesions are usually irritable, nervous, mentally distracted by the fear engendered by their hopelessness, wasted in body, malodorous in the case of superficial ulcerations, and often racked with pain. To care for those having these symptoms the physician and the nurse must put forth their very best efforts, working hand in hand, in order to effect a result. My purpose is to offer for your guidance certain general and specific suggestions for the care of such patients.

Because of the type of disease and its prolonged period of chronicity, the general health and strength of the patient require first attention. Usually such patients are very finicky regarding their food, and it therefore devolves upon the nurse to interest her patient in taking nourishment. This may be effected by coaxing and by the use of decorative and tempting articles of diet to attract the appetite.

Bowel hygiene, is a very difficult and perplexing task, medication with laxatives, purgatives or enemata must be alternately given to be effective. In chronic constipation of the gastro-intestinal malignancies, a colon irrigation often relieves where drugs prove unavailing, and the best method for this is with two tubes in the rectum, one small inlet and one large drainage. Caustics in the cleansing solution are contraindicated, simple solution of saline is bland and effective. In cases where an artificial anus or a colostomy is present, frequent cleansing douches through both ends of the open gut eliminate obnoxious odors and relieve discomfort. Keeping the surrounding skin clean and well anointed with bland ointments prevents erosion, irritation, and associated pain.

In malignances of the mouth, proper hygiene is essential. Frequent irrigations of salt solution alleviate pain and discomfort. A thin solution of glycerine and lemon juice applied to a sorely parched tongue and dry mucosa relieves burning and irritation. Brushing the teeth with cotton when the gums are sore avoids the painfulness caused when a bristle brush is used. A common thin corset steel makes an admirable and serviceable tongue scraper. Paper napkins and cups make excellent, clean, easily disposed-of receptacles for mouth and nose discharges. Annoying retronasal and pharyngeal irritations are often relieved by a few drops of mineral oil, plain or mentholated instilled into the nose and allowed to trickle backwards into the throat.

Food passing over the inflamed and sore lesions in the mouth causes irritation, loss of appetite, and abstention from eating. The tactful nurse, in such cases, feeds her patient frequently with soft or liquid foods, often aromatically flavored, and in such forms as permit easy swallowing. Dropping liquid food beyond the ulcerated lesion often avoids irritation and pain, and presenting the food at a comfortable temperature, and

pleasantly served, makes eating more agreeable. When for any reason eating is not possible, rectal feeding or injection of food through artificial openings may be required. Rectal feeding into a bowel packed with feces can hardly be accomplished successfully, the rectum must first be cleansed with enemata and a period of rest allowed before the feeding is given. The nutrient solution should be at body heat and be fed very slowly, for rapid feedings stimulate evacuation. Rest after feedings is essential for good results. Feedings through a gastrostomy or jejunostomy tube requires patience and accuracy; rapid feedings may cause collapse.

The skin of malignant patients must be especially cared for. Due to the nature of the disease, cachexia and trophic disturbances are frequently present. Bedridden patients must be specially guarded against bedsores. Frequent change of linens, dressings, and altering the patient's position prevent and relieve bedsores. Often an offensive malignant ulceration can be made less so, and the odors markedly modified, by the application of a simple sugar dressing. As these lesions persist for long periods, extravagance in dressings is hardly fair to the patient. Ingenious methods and forms are necessary to properly cover a lesion efficiently and economically, and it is up to the nurse to be of service in suggesting and advising them.

All the resourcefulness of the nurse is called upon to temper the mental state of a chronically ill patient. Pain is a depressing symptom, often severe and racking. Dosing with opiates in the beginning of the disease is improper unless the condition will be terminated in a short time, but unfortunately, the ordinary malignant patient lingers on for a long period. When morphine is used in the beginning of the disease it loses its value as a pain destroyer in the terminal stages, when it might be employed to better advantage. The judicious use of coal-tar products, alone or in conjunction with codeine, often obviates the necessity of resorting to immediate morphine therapy. Alternating the drugs used and the time of administration, gaining the confidence of the patient and making him believe in the therapeutic value of the drug given, often serve to tide over a severe paroxysmal attack of pain. Where oral administration is possible, hypodermic injections can be avoided; when the patient cannot take drugs by mouth, rectal suppositories often effect the desired result. Hypodermic injections should be given in emergencies and in such manner as to bring immediate relief, hesitation in emergencies is bad policy. Nervousness and fear in the mind of the patient are the most difficult attitudes which the nurse, even more than the doctor, is called upon to care for. Very often, knowing the conditions and constantly awaiting the dread moment of fate, despondency overcomes all the reserve mental energy of the patient. Then it is that the cheery, resourceful, tactful, pleasant nurse must bring all her intelligence to bear in devising ways and means to combat these mental disturbances. Impatience, half-hearted consolation, is far from the method to use in handling the mental condition of a cancer sufferer. Ability to get the patient interested in something besides his own condition constitutes a real triumph for the nurse. Hydrotherapy, physiotherapy, massage and graded exercise ofttimes relieve both the mental and physical symptoms of the patient.

Having so far discussed in a general way the nursing care of the malignant patient, let us now consider his care specifically under certain

conditions of radiation. At the present time we believe that surgery, radium and x-ray therapy offer the best means of caring for malignant lesions. My remarks will be confined to the latter two.

Radium, an element discovered by the Curies in 1898, gives off a radiant energy which reacts on body tissue either to stimulate, destroy or regenerate. It may be used in the form of the element itself as radium sulphate or bromide, or in the form of emanation, a gas constantly given off as it disintegrates. Radium is used practically in the form of tubules, plain or encased in metal seeds or needles, or in tubes. It is applied directly to the lesion in the form of plaques, molds, or packs; introduced directly into the tumors or placed into hollow cavities alongside the growth. When applied locally, in the form of masks, these may be of varying types and shapes and must be worn for varying periods of time. Frequently adjustment to cleanse them and relieve the patient of awkward positions may be required. Care must be used not to break the molds and lose the radium and, in replacing, to set them properly. When held in place by cords or straps, cotton padding at such places where the straps or cords pull tightly will ease discomfort. Where large plaques are used and the patient is required to lie in one position a long time in order to receive the prescribed dosage, interruptions for short periods of rest may be had, and the treatment continued later, providing care is taken to reset the pack properly and record the time the pack has been off.

Where the puncture method is used, frequent cleansings of the lesion to remove débris are necessary. If dressings have to be changed on account of discharges, care must be taken in removing them to observe whether or not any radium applicators have been pulled from place.

In cases where radium is placed in the uterus or vagina, toilet privileges should be barred to the patient. The bedpan should always be examined for radium applicators before being emptied. When abdominal distention is present, giving an ordinary enema to a patient with radium tightly packed with gauze in the vagina causes pain and distention.; a two-tube irrigation should be used. Patients having radium applicators in the uterus and rectum frequently experience difficulty in voiding, catheterization may be required and this should be done before abdominal distention becomes painful. Every eight hours is usually sufficient to give the patient relief and comfort.

Patients undergoing radium treatments are fluid deficient, and have tendency to acidity; forcing fluids is therefore essential, especially alkaline solutions such as citric acid fruit juices, and small quantities of sodium bicarbonate. Radiation also has a tendency to create nausea and gastric discomfort, so overloading with food is highly undesirable. In preparation for radium therapy the usual surgical preoperative preparatory procedures are carried out. Radium puncture work is especially a surgical procedure.

Now as regards x-rays: These, which were discovered by Konrad Roentgen in 1895, have played an important part in our treatment of malignant cases. X-rays formed by the sudden stoppage of high-powered electrons passing through a vacuum at enormous speed are a potential source of good, but may, when improperly used, cause severe damage. Patients receiving x-ray treatment must be guarded against over-dosage or burns, and it is to the nurse that the doctor looks for notice of the beginning of any untoward reactions. X-rays are

usually employed for treating large body areas and those not readily accessible to radium applications. When large doses, or frequent treatments are given, there may occur symptoms of toxemia from the rapid absorption of destroyed body products or from the rays themselves. It is advisable therefore to have patients prepared beforehand by proper bowel hygiene and light diet. A full stomach and a clogged bowel are not at all the proper condition under which to apply x-rays. Nausea or vomiting, occurring after treatments, can be controlled by citric acid fruit juices, small doses of sodium bicarbonate, or ten drops of tincture of belladonna. It is well to have patient drink a glass of lemonade or orangeade before and after x-ray treatment; this often forestalls the occurrence of nausea and vomiting.

Skin which has been treated by x-rays should be carefully protected, iodine or other irritants, over-hot water bags are contraindicated. Light boric acid wet dressings applied to an inflamed, tender, painful, swollen area often bring relief. Where treatments are to be given over the pelvis, it is well to have the patient first empty the bladder and rectum. After treatments, the patient should rest: sleep is essential to the preservation of the patient's strength. Make it easy for him to sleep. Plenty of good, fresh water goes a long way towards helping the body care for elimination of the waste products of the disease.

In conclusion, the nurse must engender in the patient and his surroundings a general attitude of hopefulness. Healing following radiation therapy requires a long period of time, and the patient must be helped to keep up his courage and patience. The nurse must remember she is the doctor's aid, that he trusts her, and she must work with him for the benefit of the patient. Her efforts proffered and spirit of willingness will find full reward in the satisfying knowledge of the good she has really accomplished.

### *Human Relations*

". . . Most of your work will have no threat of tragedy, and though for a time there is frequently apprehension, success and happy issues are far more common than the sad. And even the sorrowful experiences that every physician goes through are far from being a regrettable part of his work. President Patton, of Princeton, told us once when I was a student in his course in Ethics that a young man who was brought up carefully, shielded from all the evils of the world, might pass as a moral person, but to his mind he had the morality of a clam. And so the person who has not gone through, for himself or others, periods of distress and anxiety and even gloom, has only the visions and emotions of a clam. Unrelieved sunshine does not bring out, it obscures, the greatest beauties of color and outline. I first saw the Grand Canon of the Colorado in brilliant midday sunlight and saw it with a distinct sense of disappointment except for its vastness. Only when the shadows began to come were there really visible the marvellous colors and shapes that make it one of the wonders of the world. And just as it is only through contrasts that one can appreciate either physical or spiritual beauty and the satisfaction that comes from them, likewise it is only through knowledge of great trials that one sees the real happiness that they contrast with. Only then also does one gain the comforting sense of usefulness to others in times of trial. . . ."
—David L. Edsall, M.D., "Physician and Patient: Personal Care," edited by L. Eugene Emerson, Harvard University Press, Cambridge, Mass., 1929.

# Nursing by Religious Orders in the United States

## *Part I, 1809–1840*

ANN DOYLE, R.N.

*"They who lived in history . . . seemed to walk the earth again."—Longfellow.*

IN November, 1823, the Daughters of Charity of St. Vincent de Paul were asked to take charge of the Baltimore Infirmary, connected with the Medical Department of the University of Maryland;[1] this date marks the first instance, thus far discovered, of Religious in active hospital work in the United States.

The first Americans, however, to be nursed by Sisters were soldiers of the Revolutionary Army. During the siege of illness from smallpox and scarlet fever which attacked the troops during General Arnold's expedition against Quebec, "over a hundred" had to be removed to the hospital; "those who were not so sick" were "visited every day by the 'older nuns.'"[2] Lieutenant Nichols, in his diary, tells how they were nursed and by whom:

> March 16, 1776, was removed to the Hotel Dieu, sick of the scarlet fever, and placed under the care of the Mother Abbess, where I had fresh provisions and good attendance. For several nights the nuns sat up with me, four at a time, every two hours. Here I feigned myself sick after I had recovered, for fear of being sent back to the Seminary to join my fellow-officers, and was not discharged until I acknowledged that I was well. When I think of my captivity I shall never forget the time spent among the nuns who treated me with so much humanity.[3]

Later in the same year, at the Battle of Three Rivers, the wounded Americans were nursed by the Ursulines:[4]

> The American loss in the Battle of Three Rivers was about two hundred persons and twenty-five killed, most of the latter being from Wayne's and Maxwell's Divisions, who had borne the brunt of the fight. Chaplain McCalla, of the *First Pennsylvania*, was among the prisoners. The British loss was eight killed, including the surgeon of the Thirty-first and three men of the Tenth Regiments, and nine wounded, eight of whom were of the Sixty-second Regiment. The wounded of both sides were taken together to the Convent of the Ursulines, where they received humane treatment at the hands of the nuns. The prisoners were released by Carleton on their parole, and sent to New York on the 6th of August.[5]

During the early years of the new republic, that is from the end of the war to the beginning of the new century, 1800, the need for nursing, as an institutionalized endeavor, was not pressing; the population was small and was scattered over a large area.[6] The number of sick, except in time of epidemic was not so numerous as to demand care outside the natural family group. Strangers or travellers who were taken sick were admitted to

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[1] Archives of the Community, St. Joseph's, Emmitsburg, Md.

[2] Smith, T. E., "Our Struggle for the Fourteenth Colony: Canada and the American Revolution," v. 2, p. 272.

[3] Nichols was Second Lieutenant of Captain William Hamilton's Company, transferred to the First Pennsylvania, and left the Service as a Major of the 6th Regiment. He died at Pottstown, Pa., February 12, 1812. "Proceedings, Delaware Historical Society," v. 1, p. 23.

[4] "A company of Ursulines went forth from Quebec on October 8, 1697, to take charge of a hospital founded at Three Rivers on the St. Lawrence, by Mgr. de Valier, Bishop of the former city. They were five in number, four professed and one lay Sister." (Carrier, Claude W., "History of Religious Orders," p. 294.)

[5] Jones, C. H., "History of the Campaign for the Conquest of Canada in 1776," p. 77.

[6] *Niles Weekly Register*, 1810, published the returns of the census for that year: there were 7,239,903 persons, in 19 states, 6 territories, and the District of Columbia, of whom 1,191,364 were slaves, and 1,681,276 were children under 10 years of age.

the homes of the charitably inclined and nursed back to health or properly buried.

Brownson, in her "Life of Prince Gallitzin," repeats an anecdote related by the young prince-priest during a mission in Virginia, in 1797, which in part illustrates the custom of taking sick strangers into homes for care, without reference to class, creed or nationality:

> In Jefferson County, at a village called Middleway, since changed . . . to Cliptown, near Martinsburg, Virginia, . . . there lived a Mr. Adam Livingston, a Pennsylvanian by birth, of Dutch descent, and a Lutheran in religion, an honest industrious farmer . . . with his large family on a handsome property there. He was kind, generous and hospitable. . . . A poor Irish traveller, a Catholic being ill while in Mr. Livingston's neighborhood, was taken into his house, carefully nursed and attended through his last sickness, and properly buried.[7]

But as the country developed, immigration and emigration entirely changed the early aspect. The village days when each man knew his neighbor had passed, and a community of comparative strangers had succeeded. The long and trying voyages at sea, and the tedious and dangerous travel on land, caused a great deal of illness, so that many immigrants and emigrants upon landing at their destination were in such physical condition as to make hospital care a necessity. All the seaport cities were faced with the same dilemma: immigrants were needed, and their entry into the country was a source of State revenue. But they later became a problem, says Gregory:

> The immigrants into the United States up to about 1830 were generally welcomed, for their labor was useful and the sum efficient. But [illegible] the number of immigrants increased and there were repeated charges that they included a large proportion of paupers, criminals, and infirm, who were shipped to America by the poor-law authorities. Many of the immigrants soon became inmates of the American poor houses. . . . New York established an agency to receive the immigrants, and to see to their comfort on arrival and help them to find work and a home. This system continued until 1876, when immigration was declared a Federal matter, and Federal legislation to control it was passed in 1882.[8]

Great activity in shipping and the development of manufacture likewise placed upon the residents of the cities the care of growing amounts of institutional dependency.

All of the early hospitals, such as the Pennsylvania Hospital, Philadelphia; New York Hospital, New York; Charity Hospital, New Orleans, and others, made definite provision for the care of the seaman and the immigrant. The Pennsylvania Hospital made definite provision for "strangers," "sick and distempered immigrants." Up to 1740, whenever sick immigrants arrived in Philadelphia, it was the custom to place them in empty houses about the city, and in this way infection was frequently communicated to the neighbors. Philadelphia was scourged from time to time by epidemics of yellow fever and other pestilential diseases, and her health officials made great efforts to protect the city from infections from without.[9]

By an Act of Congress, every seaman in the merchant service paid twenty cents a month (deducted from his wages) for his support, if sick or disabled. This not being sufficient for all who applied at the New York Hospital for relief, the governors petitioned Congress for the $15,141.28 deficit for 1804–1819.

The nursing in these institutions

[7] Brownson, S. M., "Life of Prince Gallitzin," quoted by Murray, J. O'K. in his "Popular History of the Catholic Church in the United States, 1876," p. 399.

[8] Gregory, J. W., "Human Migration and the Future," p. 91.

[9] Morton and Woodbury, "The History of the Pennsylvania Hospital, 1751–1895," p. 4.

(with the exception of Charity Hospital, after 1834) was carried on by lay women and men hired for the purpose by the hospital managements, somewhat on the level of the old orderly service. Many writers bear testimony to the fact that the nursing was not very well done, and that the type of person doing it was not of a high order of intelligence or moral status:

> There were no training schools, the standards of nursing were not high, the work did not, as a rule, appeal to the intelligent and high-minded of either sex. The Protestant Sisters in Germany and the Roman Catholic Nuns in France were the pioneer nurses of the world, and were the only systematic followers of that calling until Florence Nightingale, in 1860, devised and launched the modern training school for nurses.[10]

The missionaries, Protestant and Catholic, in their travels through the country became more and more aware of the growing need for institutionalized nursing care for the sick as well as teachers for the young and guardians for the orphans. Each and all appealed to Europe for help, but help was slow in coming to them. Many of the priests had come to the country from France, following the promulgation of the Concordat of 1790, putting all religious orders under government control; and many from Ireland, following the Irish Rebellion of 1798, who had been accustomed to the help of Sisters and Nuns in caring for the sick, aged, and orphans, and finding that they could get no help from the European convents finally set about to see what could be done toward organizing American groups.

The first American order in the country was the Daughters of Charity of St. Vincent de Paul, founded in Baltimore, Md., in 1809, by Arch-

The Paca Street House, Baltimore
Within the shadow of St. Mary's Seminary.
(Courtesy The Macmillan Company)

bishop Du Bourg, then president of St. Mary's Seminary.[11]

[10] Sheldon, Edward W., "Speech, Commemoration Exercises, 100th Anniversary of the Society of the New York Hospital," p. 31.

[11] While, strictly speaking, the Daughters of Charity were not founded by Archbishop Du Bourg, he did, nevertheless, make it possible for Mother Seton to begin her great work. "Come to us, Mrs. Seton. We will help you form a plan of life which will shelter them (probably her five little children) from the dangers which threaten them here; you will find in Baltimore more consolation of faith (Mother Seton had become a convert to the Catholic Faith following the death of her husband) than you could find elsewhere. We desire to form a school for those children whose parents wish them trained to piety. Why delay? Without buying or building, we can rent a house. Courage is not wanting on your part, and the experience of the first year will enlighten you and your friends on the measures to be adopted in the future." This was in the spring of 1808, and in June of the same year Mother Seton and three of her children arrived in Baltimore from New York and were welcomed by Father Du Bourg's mother and sister, with whom he lived, and here she remained all summer getting the little house on Paca Street ready for the new school. The little brick house was sufficiently large to accommodate about ten persons besides Mother Seton and her three children: the rent was two hundred and fifty dollars a year. (De Barberey, "Elizabeth Seton," First Trans. ed. 1927, p. 207–211.)

THE LOG CABIN OF 1812

Three years later, 1812, two other groups of Sisters were founded, namely, the Sisters of Charity of Nazareth, by Father David, a French priest, a member of the Order of St. Sulpice (the order to which Father Du Bourg belonged); and the Sisters of Loretto, by the Rev. Charles Nerinckx, another exile from France. Both of these communities were organized in Kentucky. Both were begun amidst the most extreme poverty and hardship. The former group at once embraced nursing as a primary duty, and the three beginners, Teresa Carrico, Elizabeth Wells, and Catherine Spalding, went to and from their Motherhouse, "a roomy cabin of unhewn logs in a corner of the Seminary Farm," out to the sick in the surrounding country on horseback."

The next important American-founded group, so far as nursing is concerned, was the Sisters of Our Lady of Mercy, founded in Charleston, S.C., in 1829, by Bishop John England, a native of Cork, Ireland.

Following quickly upon the founding of these American Sisterhoods, other groups of Sisters and Nuns either came to the country to settle or founded American branches. Practically all of them organized schools and addressed themselves to the education of the young, making other works of mercy appear as a secondary consideration. The reason for this is quite obvious and is clearly set forth by a Sister of Charity of Leavenworth, Kansas, as follows:

> In America, the logic of necessity compelled the Sisters to turn to teaching as the only means of "Every head" at their command. The poor and helpless, however, were not forgotten, and the auxiliary was usually the maternity of the hospital and the orphanage.

MOTHER GONZAGA STAFFORD

[illegible] Vol. XXIX. No. 9

[illegible]

" History of the Sisters of Charity of Leavenworth, Kansas, by a Member of the Community," p. 12, 13.

In a new country, too, the lack of schools for the training of the young is always more keenly felt than asylums for the wretched. . . . All manner of good works is the province of the Daughters of St. Vincent; they have ever been mindful of his command "What lies at your hand, that do" . . . and so it happened that the first American Community of Sisters of Charity became teachers and nurses.[13]

It is reasonable to assume that the Sisters of Charity nursed the sick wherever they were, Philadelphia, New York, Baltimore, because it was a natural inheritance of Mother Seton, herself the daughter of the celebrated Dr. Richard Bayley, the first physician of the Port of New York. During the summer season she was accustomed to spend a few months with her father in his delightful home on Staten Island. In August, 1801, yellow fever raged among the incoming Irish immigrants. Dr. Bayley was seen everywhere, day and night, among the dead and dying, himself falling a victim to the disease, September 5, 1801.

Mother Seton begged to be allowed to help nurse the wretched people, but her husband and father forbade her, not alone because she was not well, but because she was nursing an infant baby. At the close of one of the most terrible days of the epidemic she wrote to her sister-in-law, Rebecca Seton, who was known for her good works as the "Protestant Sister of Charity."

Rebecca, I can no longer sleep. The dead and dying absorb my mind. Babies perishing on the empty breasts of expiring mothers. This does not proceed from my imagination; it is the very scene that lies about me. My father says that no one has ever seen the like of it. At this moment there are twelve children certainly doomed to die from mere want of food. They are beyond the aid of substistance except that coming from their mothers' breasts. But, alas! these unfortunates can no longer offer to them, because they have been drained by the sickness which devoured them, while they were aboard. O God, Merciful Father, how gladly would I give to each of these poor little creatures a part of the inheritance of my own child, if it only depended on me. But Rebecca, they have a Provider in heaven who will sooth the pangs of the suffering innocent.[14]

Surely, then, she did not neglect the sick poor after she had committed herself to a life of charity. Shea states that:

The sisterhood thus formed (in 1809) and consisting of ten members began at once to teach poor children; to visit the sick; and before long opened a boarding school for girls.[15]

It has been difficult to record with any reasonable degree of comprehensiveness or completeness the contribution to the development of nursing made by the various religious groups, Catholic or Protestant, because of the limitations and difficulties of the times, and the extreme modesty and self-effacement of the women who made up the groups. To quote Senior Paula Dunn, the Sister Visitatrix of the Eastern Province of the Daughters of Charity of St. Vincent de Paul:

You know, of course, that these were not days of statistics: all the work had but one concern—to do well what they did and left few or no records of their methods, organization, and other items so vitally important today.[16]

The early history of any institution or movement is more or less scant in details, and the details are the actions of individuals. When the pioneers were working they were not planning history for posterity. Those early Religious could not foresee the time when History of Nursing would be a requirement in a nursing-school curriculum. Most of those women, in their sincere humility, considered their

[13] "History of the Sisters of Charity of Leavenworth, Kansas, by a Member of the Community," p. 12.

[14] De Barbevy, "Elizabeth Seton," pp. 34–35.

[15] Shea, "History of the Catholic Church in the United States," II, p. 647.

[16] Letter to Ann Doyle April 27, 1929.

labors unworthy of praise and hoped only that God in His infinite mercy would discount their frailties and accept what they had to offer. And so it is that we know our nurse-religious ancestors only by vague tradition, letters or journals kept for the purpose of making progress reports to their superiors and containing only the barest outline of the most important happenings;[17] or the chronicles of their work were set down by admiring persons. To these latter we are indebted for much that we have; but these, too, are scant, fragmentary, and many times confusing as to time, place, or specific order,—"Sister of Charity," "Sister of Mercy" being used indiscriminately instead of a specific name. Likewise, the terms "hospital" and "nurse" are rarely met with in the indexes of the older books on social, economic, or medical subjects.

As previously stated, the first known date when Religious assumed charge of a hospital in the United States has been 1823. This hospital was the Baltimore Infirmary, the present University of Maryland Hospital, Lombard and Green Streets, Baltimore, Maryland, connected with the Medical Department of the University of Maryland. Dr. Cordell describes the erecting of this institution as one of the "most important events during this period (1823)," and states that "while clinical teaching did not occupy the prominence it now has, the faculty nevertheless recognised the need of hospital facilities."

It is described as extending from a point on Lombard Street 78 feet west of the corner of Green Street, running west 75 feet, then south to Whiskey Alley, 174 feet, then east 75 feet, then north 174 feet, completing a parallelogram. The lease was dated July 10, 1823, and was for ninety-nine years, renewable forever. The building was ready for patients on September 20, 1823.

The Infirmary was the private property of Professors Davidge, Potter, Hall, De Bults, Baker, McDowell, and Patterson. The building cost $11,598; the furniture, permanent and movable, $2,520.

There were four wards, one of which was reserved for eye cases, ophthalmology being a prominent subject of the course. There were two resident students, each of whom was required to pay $300 per annum, in advance, for board, washing, and so forth. The visits of the medical and surgical staff were paid at noon daily. Only acute cases were first admitted, the charge for whom was $3 a week, which included everything.

One of the early regulations was that the Bible should be read each day audibly in each ward.[18] Professors were compelled to use their own instruments, and they could not obtain even so necessary an article as leeches.[19]

[17] This may be accounted for by the fact that postage was very high, and mail delivery very uncertain:

"Rates of Postage established by Act 9th of April, 1816, are as follows:

"For every letter composed of a single sheet of paper, conveyed not exceeding 30 miles, 6 cents; over 30 miles and not exceeding 80 miles, 10 cents; over 80 miles and not exceeding 150 miles, 12½ cents; over 150 miles and not exceeding 400 miles, 18½ cents; over 400 miles, 25 cents.

"For every double letter, or letter composed of two pieces of paper, double these rates; and for every packet composed of four of more pieces of paper, or one or more other articles, and weighing one ounce avoirdupois, quadruple these rates, and in that proportion for all greater weights; provided that no packet of letters conveyed by the water-mails shall be charged with more than quadruple postage, unless the same shall contain more than four distinct letters." (Bogart and Thompson, "Readings in the Economic History of the United States, 1916," p. 274–275.)

[18] Cordell, E. F., M.D., "University of Maryland: its History, Influence, Equipment, and Characteristics, Etc., 1807–1907."

[19] *Ibid.*, p. 75.

Application was made to Emmitsburg in August for Sisters to take charge of the Infirmary, and they arrived in November. No mention is made of what they did until 1834, when an article on the Baltimore Infirmary appeared in Gedding's *Baltimore Journal*. This article stated that the Infirmary is under the government of the University of Maryland, expressly for clinical teaching; that it has eight wards and about ninety beds: three wards for seamen; three wards for male white citizens; one ward for females; and one ward for blacks. The patients still pay $3 a week, "which entitles them to all the advantages of the house." And "many individuals of respectability and standing enter the house for medical and surgical care."

> The affairs of the house are under the direction of a superintendent, and its internal economy is attended to exclusively by the Sisters of Charity, who devote their constant and unwearied attention, with a kindness truly sisterly, to the comfort of the sick.[30]

The names of the Sisters who assumed charge of this hospital are not given, but Sister Ambrosia is said to have been the first. The *Catholic Almanac*, 1842, records the death of Sister Ambrosia Collins,[31] at the Baltimore Infirmary, and states that:

> The death of this excellent Sister of Charity was a public calamity. Not only were her services invaluable to the hospital, over which she so wisely and vigilantly presided for so many years, her generous charity was felt far and wide, while the amenity of her disposition and her sweetness of manner gave it a tenfold charm in the eyes of the world. Rich in every good work before God and man, she left the earth amid the tears and benedictions of all who knew her, to reap the glorious fruits of her exalted virtue.

There is, as has been stated in a previous paragraph, no record of the nursing practice in vogue during these early years, but, judging from what the practice of medicine was at the time, it is reasonable to suppose that it was very simple, and was confined to procuring cleanliness, nourishment, and safety for the sick, and the administration of simple medication. Thus the work of the Sisters was confined to the kitchen, the laundry, supervision of the wards, and taking care of the spiritual welfare of the patients.

New York Hospital has records of "Selected Medical and Surgical Cases," dating from 1809–10 and on. These records, all written by hand, in large ledgers, bound in calf, contain very minute descriptions of cases and the treatment which had been applied. These records give an excellent idea of what the nursing must have been; much of the treatment was administered by the "house doctor," who was assisted by men or women orderlies or helpers. No mention whatsoever is made of any orders ever being given to "nurses." There are frequent references to certain treatments which one would suppose were given by nurses, such as, "gave douches," "yeast gargle," "charcoal poultice," "yeast poultice," "bread and milk poultice," "nutritive enemata of milk blood warm, three times a day, alternated with soup," "wet dressings of lead and opium," and of "sal ammoniac in vinegar." And particularly one case, a female patient in Ward No. 15, for whom was ordered "a warm bath, to be followed by an enemata common."

Several medical men, whose contact has reached back to these days through immediate relatives who were doctors,

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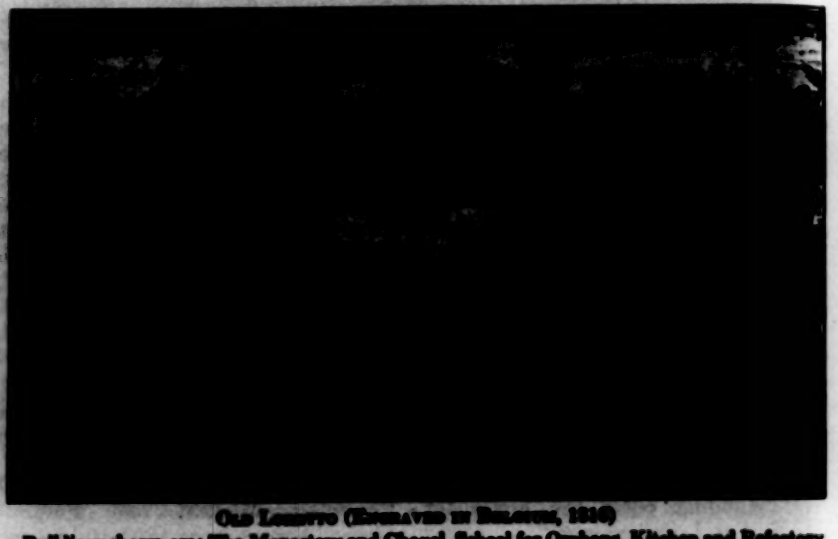
[30] "North American Archives of Medical and Surgical Science," vol. 1, No. 1, October, 1834. (Gedding's *Baltimore Journal*, v. iii, 1834–35.)

[31] This is probably an error, as the Obituary List of the Sisters of Charity records for this date the death of Sister Ambrosia Meagher at Baltimore, Md., but no Sister Ambrosia Collins.



Old Lorette (Engraved in Relation, 1840)

Buildings shown are: The Monastery and Chapel, School for Orphans, Kitchen and Refectory, Garden, Servants' and Smoke House, House for Guests and the Sick, Confessor's House, Kitchen, Stables, Gate to the Road.

are all of the opinion that the nursing done by the Sisters and Deaconesses was of a very high order of excellence. To quote but one of these men:

Comparatively speaking, the nursing was excellent. The Sisters worked under the immediate supervision of the attending physicians and the resident physicians. Many of these Sisters were women of great intelligence, and, for the times, superior education. The doctors held classes for the instruction of the Sisters, and the head Sisters instructed their subordinates in the details of nursing technic. They did what the good nurse of the present day does—carried out the doctor's orders with promptness and intelligence.[2]

The next hospital work to be undertaken by this group of Sisters was the St. Louis Mullanphy Hospital, St. Louis, Mo., in 1828:

In 1828, application was made to the Community at Emmitsburg to procure Sisters to open a hospital in St. Louis, property having been donated by John Mullanphy for this purpose; but it was not until November 6, 1828, that four Sisters arrived to take possession. The work was commenced in a log house on Spruce Street, between Third and Fourth Streets, containing two rooms and a kitchen. In these early days they had many privations to endure, notwithstanding Mr. Mullanphy's generosity, and the kindness of Bishop Rosati.

In 1831, the cornerstone in a brick building was laid, fronting on Spruce Street. It was completed in 1832, being the first hospital of its kind west of the Mississippi River.

During the year 1832, Asiatic cholera swept the city, and the hospital was crowded with persons afflicted with the disease. Because the city could not obtain nurses to man the hospitals which had been erected to care for the stricken citizens, all of the patients from these hospitals had to be removed to the Sisters' hospital.

In 1843, the St. Louis Mullanphy Hospital, the first Catholic hospital in the United States, was incorporated by the St. Louis Hospital Association. Asiatic cholera again swept the city in 1849, and again in 1866. During the Civil War soldiers of both armies were nursed in this hospital. In 1873-74 a lot was purchased and the hospital removed to Montgomery Street, near Grand Avenue.

The four Sisters who came in 1828 were Sister Frances Xavier Love, Superintendent,

[2] William Travis Howard, Jr., M.D., School of Hygiene, Johns Hopkins University, Baltimore, Md.

Sister Rebecca Dullone, Sister Francis Reggio, and Sister Martina.[25]

The *Catholic Almanac*, 1840, states:

> The patients have exceeded 1,000. An addition has been made with very comfortable accommodations for lunatics.

None of the earlier hospitals seemed to have turned their backs on the mentally ill.

The Sisters of Our Lady of Mercy, of Charleston, S. C., were the next to undertake hospital work. This hospital had its beginning in a way differing from the other two just described. The *Catholic Almanac*, 1839, describes it as the

> Hospital of the Society of Working Men, Brotherhood of Saint Marino, an association of upwards of 100 respectable, well-conducted mechanics and laborers, who support this hospital for their own benefit by stated contributions. This establishment is attended by the Sisters of Mercy.

This Society of Saint Marino was founded by Bishop England to meet the need of caring for the large number of homeless men, principally immigrants, who had come to Charleston seeking employment.

During the years 1830–1840, the city of Charleston was scourged with visits from cholera and yellow fever. The Sisters of Our Lady of Mercy were greatly taxed in attending in the various parts of the city, and it was to afford them an opportunity of caring for more people that

> the Brotherhood of San Marino rented a house, furnished it with hospital appliances and placed it under the charge of Sister Mary Vincent Mahoney and Sister Mary Veronica Cagney.

Here the sisters worked day and night, some of them falling at their posts, victims of the fever.[26]

When the epidemic broke out, the Sisters offered their services to the sick of the city to be used "in any way the Board of Health might direct."[27]

Charity Hospital, New Orleans, was the first hospital established by private beneficence, for the founding of which (about 1720) Jean Louis, a sailor, afterwards an officer in the Company of the Indies, left 12,000 livres ($2,500). This was destroyed by the hurricane of 1779.[28] The New Charity Hospital (San Carlos) was founded in 1870 and endowed by Don Andres de Almonester y Roxas: it became the City Hospital in 1811, and was later destroyed by fire. The present Charity Hospital, built at a cost of $150,000, dates from 1832–34. Since 1834, the hospital has been under the charge of the Sisters of Charity.[29]

The *Catholic Almanac* 1834, records the fact that the "Maryland Hospital, in Baltimore, is attended by the Sisters of Charity." This hospital was located on North Broadway, on the site now occupied by the Johns Hopkins Hospital and was a state institution; both general medical and surgical cases as well as insane cases were treated here.

The Sisters remained here until 1840; the *Catholic Almanac* for 1841 recording the fact that

> The Sisters, having retired from the Maryland Hospital which belongs to the State, have purchased several acres of ground in a very eligible and healthy spot, on the skirts of the city, now Mt. Hope Retreat, where they intend to open a hospital as soon as the buildings can be prepared. At present they now occupy a house on Front Street, in which only a few patients can be accommodated.

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[25] Hyde, William, and Conard, Howard L., Eds., "Encyclopedia of the History of St. Louis, in 4 vols., 1899, v. II, p. 1261.

[26] American Catholic Historical Society of Philadelphia, Records, Vol. XV, September, 1904.

[27] Shea, Vol. III, p. 881.

[28] Catholic Encyclopedia, Vol. 7, p. 448.

[29] Fortier, M., Ed., "Standard History of New Orleans," p. 448.

The seventh hospital to be opened by Sisters was St. Vincent's Infirmary, Louisville, Ky., by the Sisters of Charity of Nazareth. This hospital was the fulfilment of Mother Catherine Spalding's dearest wish,—to provide a place for Louisville's sick. Her opportunity came following the great cholera epidemic of 1832-33, when the number of orphans became so great that a larger place had to be found in which to house them. The new orphanage had a "few spare rooms," and these became the refuge for the sick in Louisville, and were called St. Vincent's Infirmary. The quiet rooms won the favor of the city physicians. The Sisters' reputation as nurses spread rapidly; the "few rooms" were soon inadequate, and Mother Catherine was again forced to move into larger quarters. This modest infirmary was the foundation of the present excellent St. Joseph's Infirmary.[28]

The Infirmary at Richmond was opened on August 25, 1838, by the Sisters of Charity of Emmitsburg. The *Catholic Almanac*, 1839, records that the "Infirmary at Richmond is under the Sisters of Charity." In 1840, from this same source we find that there are "three Sisters and forty patients at the Richmond Infirmary; in 1841, four Sisters and forty patients." Aside from these meager details we have no records relative to it, its organization or support.

In 1836, the United States welcomed the Daughters of St. Joseph. Six Sisters under the auspices of Bishop Rosati, of St. Louis, opened an establishment in Illinois. They were members of a French order, founded in 1650, by Mgr. Henry de Maupas, Bishop of Puy. These Sisters augmented the little band of nursing Sisters already at work, for everything included in the words, *charity, mercy, education*, claimed the attention of these modest Daughters of St. Joseph.[29]

In order to depict the magnitude of the effort represented by the organization and development of these hospitals it would be necessary to go more fully into the social, economic, industrial and political development of the country during the period covered than the compass of this paper permits; practically all that was done was accomplished by the Sisters themselves, and under conditions which would have repelled many less zealous and stout-hearted. It was long before the days of skyscrapers, universal automobiles, telephones, telegraphs, elevators, perfect-oven, central-heating systems, sybaritic plumbing, electric light or even gaslight. In 1816, Father Nerinckx "sent the Sisters of Loretto some appliances for cooking which he found in Pittsburgh . . . they were called stoves, and cost him $100 apiece, besides the cost of transportation. They were the first to be seen in the settlement, and possibly the first in all Kentucky."[30]

The country was scourged with epidemics of yellow fever, smallpox, cholera and other communicable diseases. (The work of the Religious in these epidemics will be treated in a separate paper.) The War of 1812; the Indian uprisings; the money panics of 1819 and 1837; and the constant flow of immigration from Europe and the emigrations to the West, all contributed their share to the burden of caring for the indigent sick, while the scarcity of money and workers made the task great for the few at work.

[28] McGill, "History of the Sisters of Charity of Nazareth," p. 111.

[29] Mussey, "Popular History of the Catholic Church in the United States," p. 497.

[30] Howlett, "Life of Father Nerinckx," p. 272.

The picture of Mother Seton used as a frontispiece is from a marble tablet in the main corridor of Bachmann Building, St. Joseph's College, Emmitsburg, Maryland. This tablet was erected by Sister Juliana Chetard, daughter of Dr. Ferdinand Chetard, physician to Mother Seton.

Ed. Note.—The coming of the Sisters of Mercy from Ireland, the Deaconesses from Kaiserswerth, and the development of philanthropy in the United States until the beginning of the Civil War, will be taken up in the next paper.

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*Any Nurse, 1929*

I AM the young woman who lives in her shoes,
My money all goes to pay pledges and dues;
If I stop to buy clothing or any such trash
Some "object" sends in an appeal for its cash;
My errands, my business, my church going—all
Are planned, done and finished in view of a "call";
My patients are scattered from Guilford to Roby,
My bag must be packed without pause or delay,
By limousine, coupelet, railroad or car
I am whisked away breathless wherever they are;
Church, hospital, clubhouse—to store, bank or shop,
I rush around madly with never a stop—
All over the city my rubber heels fly—
Was ever a trained nurse as busy as I?
To care for the sick—to earn money—to give—
Is there any other incentive to live?
When I reach Heaven's gate will St. Peter, St. Paul
Say, "Get ready at once, don't unpack,
There's a call?"

—*The Johns Hopkins Nurses' Alumnae Magazine*, May, 1929, Baltimore, Md.

# Thrombo-Angiitis Obliterans

## *What the Nurse Should Know about It*

VIOLET EMPTAGE, R.N.

THROMBO-ANGIITIS obliterans is a disease of the circulation in which there is a partial or complete closure of the blood vessels, especially the arteries, in one or more extremities, usually in the lower ones. It was first described by Von Winiwarter in 1879. Its cause is as yet unknown. It has been observed that in every case of thrombo-angiitis obliterans the patient is an inveterate cigarette smoker. The disease apparently occurs mainly among young Russian Jews although authentic cases have been reported in other races. No cases have been observed in women up to the present. The reason for this is not understood and it is interesting to speculate whether the increase in the use of tobacco among women will be productive of this disabling disease.

The pathology of the disease has been extensively studied and described by Buerger. Due to a preceding inflammatory condition of unknown etiology, the blood vessels become thrombosed and narrowed and there is an impairment of the circulation. This bears some similarity to the hardening and thickening of the arteries seen in arteriosclerosis, a disease of the aged. Due to the marked nutritional disturbances of the skin, secondary to the vascular impairment, ulcerations may develop, and these, together with infection may lead to ultimate gangrene.

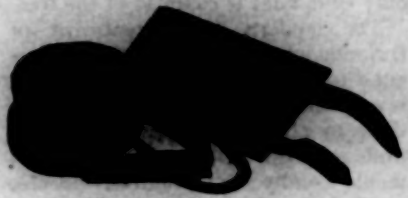
The most common symptom of this disease is called "intermittent claudication." This is a cramp or pain in the calf of the leg which comes on after the patient walks a few blocks. At times it may be so severe that the patient is forced to stop walking and rest. However, some of the most extensive cases of this disease may have no pain at all. In some instances, the only complaint is coldness of the feet.

The modern office treatment of thrombo-angiitis obliterans has undergone considerable change in the last few years. Formerly little could be done to alleviate the pain, suffering and progress of the condition. It would usually run a progressive course until gangrene developed and amputation became necessary. Today, however, an attempt is made not only to dress these cases with due surgical care, but to utilize all known methods to improve collateral circulation so that disabling amputations may be avoided.

There is a great deal for the office nurse to do under a physician's direction in the ambulatory treatment of these unfortunate individuals. Since the disease is chronic and appears to attack people in poor circumstances, the majority of these patients are inclined to become very depressed and morose. One should greet these patients with a pleasant smile and a cheerful remark. Any slight improvement which may have developed in the course of treatment should be magnified, for nothing helps as much as encouragement. The nurse must always manifest renewed interest in their condition and continually stress the point that smoking must never be indulged in. As a matter of fact, smoking is not permitted in our reception room and even the doctors refrain from smoking during consultation hours.

It is most important to emphasize rest, and to caution the patients to do the minimal amount of walking, only

that which is necessary to carry on their work. Patients with this disease should be warned against trimming their toe nails, corns or calluses too close, because of the danger of causing ulcers, resulting in gangrene in some cases.



PACHON'S OSCILLOMETER

In preparing the patient for a proper examination by the doctor, it is essential to have the patient remove all clothes below the waist. He should then be placed on a low couch or examining table in the recumbent position. Aside from the usual physical examination, a special method of examination has recently been introduced in this country in the form of the "Pachon Oscillometer." Since the use of this instrument is gradually becoming a routine diagnostic procedure in many hospitals, as well as in clinics in which this disease is being treated, it will be well to describe it here. It is an instrument for detecting and measuring the pulse in different parts of the extremities, very much like the sphygmomanometer which is in daily use in taking blood pressure. An illustration of the instrument follows (Fig. 1). This instrument has four cuffs. The largest cuff is used for the thigh, the next size for the leg, the third for the ankle and the smallest for the foot. If there is an involvement of the hand, the cuffs are applied in a like manner to the arm. This apparatus enables one to detect minute changes in the pulsations of the arteries with instrumental precision. Since the disease is fundamentally a closure of the main arteries, this instrument is invaluable in determining the arterial occlusion present. It is also an aid on subsequent examinations to determine whether the treatment is effective and to note the progress or recession of arterial occlusion. Inasmuch as these ulcerated or gangrenous wounds must be dressed frequently, the patients usually prefer to do the dressings themselves. They should be instructed to bathe the affected part with warm soapy water, at least once a day. The importance of washing their hands before each dressing should be stressed. A clean white enamel basin should be used. Sterile dressings and medications are essential. Gangrene and ulcers are usually accompanied by severe pain, so severe at times that the sufferers will say, often: "I have been awake all night, I could not get my foot in a comfortable position, it pains, pains, all the time."

The main purpose of conservative treatment in these cases is to improve the collateral circulation in the extremities so that ulcers will heal without the necessity of performing amputations. The physician may use any or all of the following methods of improving collateral circulation. The methods are: baking, diathermy, intravenous injections of hypertonic saline and postural exercises.

Baking can be carried out by means of baking machines or electric lamps which the patient can use at home.

In the opinion of most physicians, baths are more effectual and easier to carry out. To produce hyperaemia of the lower extremities, the patient should sit in a tub of comfortably hot water. The water should be no higher than the level of the hips. The patient should remain in the tub for at least twenty minutes and this can be

done as many times during the day as is practical.

Diathermy, a procedure that is sometimes used, can be executed in the office or at home. The proper way to do this is to immerse the affected foot in a basin of warm saline solution in which one electrode has been placed. The other electrode is attached to the anterior part of the leg below the knee. The amount of current can be regulated according to the comfort of the patient and given for twenty minutes at frequent intervals.

It has been found that intravenous medication in the form of five per cent, chemically pure, sodium chloride solution is very effectual because this saline increases the blood volume by drawing fluid from the tissues thereby dilating the blood vessels. To prepare this solution, have the sodium chloride weighed out in fifteen-gram portions. Add one portion to three hundred cubic centimeters of distilled water. Filter through two pieces of filter paper into an Erlenmeyer flask. Cover with sterile gauze and cook for fifteen minutes over a gas flame or an electric stove. I suggest gas or electricity, because very few offices are equipped with an autoclave. For intravenous injections the solution is then placed in a sterile three hundred cubic centimeter burette and is allowed to run into the median basilic vein by gravity. An eighteen gauge needle is preferable, and must be sharpened before each injection. If too much difficulty is encountered in getting into the arm vein, the physician may use the jugular vein of the neck. It is needless to state that no tourniquet is necessary to distend this vein. A sterile towel should be draped around the patient's neck, exposing the jugular vein, and the patient is instructed to blow his breath slowly with

A case of thrombo-angiitis with self-amputation of the middle toe and residual granulating ulcer. (Courtesy of Dr. Samuels.)

Shows typical progressive ulcers of the toes in a case of thrombo-angiitis. Note the dark color (teal) of the first two toes. (Courtesy of Dr. Samuels.)

A case of thrombo-angiitis with self-amputation of all toes and showing healing ulcers. (Courtesy of Dr. Samuels.)

partly closed lips. This brings the vein into prominence. As the injection is painless, novocaine is not necessary. Alcohol sterilization of the skin is sufficient.

Another form of therapy is the method of postural exercises. This method is used in cases in which there are no open wounds. The exercises are usually carried out by the patient at home or in the hospital. The patient is instructed to lie on a bed or couch in the recumbent position with a watch in his hand to correctly time the movements of the exercise. The legs are then elevated for three minutes. It is rather difficult for an elderly patient to do this, and in order to facilitate the procedure, a kitchen chair may be turned upside down so that the back can be used as an inclined plane on which to rest his lower extremities in full extension. Following this, the patient is instructed to sit on the bed and have his legs hang down over the edge for two minutes, and lastly to again resume the recumbent position for two minutes. This exercise should be carried out for one hour, three times a day.

After conscientious treatment, improvement in most cases is quite evident. The toe nails which were dry and brittle and poorly nourished begin to assume a pink healthy appearance. Granulation replaces the gangrenous ulcers, and finally are completely healed. The unbearable pain disappears. Thus men who were incapacitated for years are able to resume their work in most cases, and disabling and mutilating amputations are avoided in a large percentage of cases.

## *Act Establishing Narcotic Farms and a Narcotics Division in the Public Health Service*

AN act of the Seventieth Congress, approved January 19, 1929, authorizes the establishment of two institutions for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs who have committed offenses against the United States and of addicts who voluntarily submit themselves for treatment.

The act defines the term "habit-forming narcotic drug" or "narcotic" as meaning opium and coca leaves and their derivatives, and also "Indian hemp" and "peyote." This is the first time that these two substances have been included as narcotics in Federal laws dealing with the subject.

The Public Health Service was designated by Congress as the Federal agency to administer the narcotic farms, and the act creates, for this purpose, a new administrative division in the office of the Surgeon General to be known as the Narcotics Division. The institutions will be designed to rehabilitate, restore to health, and, when necessary, train to be self-supporting and self-reliance, persons addicted to habit-forming drugs who are confined or admitted thereto.

# The Opium Problem

ELLEN N. LA MOTTE

IT should be a matter of interest, if not of grave concern, to realise that there is a very serious menace to the public health of this country, namely drug addiction. In this, however, we are not alone, as other countries throughout the world are threatened with the same danger. Drug addiction may be likened to a preventable disease that is being deliberately created—a preventable disease of an incurable type, marching with relentless strides to the complete mental, moral and physical destruction of its victims. It is incurable, in that only a few, occasional cases have sufficient character to get out of the toils, once they become enmeshed. And these are so few they don't count. Thousands of patients can be taken "off the drug," but that is different. As a rule they relapse when opportunity occurs, and opportunity presents itself on all sides. There is a big difference between being permanently cured, and being temporarily kept off the drug—kept off, in most instances, by main force, in institutions and elsewhere, which is a costly proceeding. Nor can you erect institutions large enough, and build them fast enough, to say nothing of paying for their upkeep, to keep pace with the constant increase in patients of this character. Drug addiction is spreading with alarming leaps, because each new victim that succumbs means money in the pockets of a long chain of greedy individuals—individuals who do not care two hoots for public health and whose one object is to create a market for the drugs they have to sell. And drug addicts are the best customers in the world; they consume more and more each month, and find the money to pay by hook or crook. A large number of hold-ups and robberies are committed by addicts desperate and hard pressed to get the money for the next dose. A further peculiarity of addiction is the necessity to increase the dose. The five grains that satisfied a month ago, must be increased to ten, to gratify the craving, and so on, higher and higher. Addicts frequently take 60 grains of morphine in a day, while there are several recorded instances of those who take 125 grains in twenty-four hours. All of which means good business for the drug trade, but is very battering to the individual.

Being incurable, or incurable for all practicable purposes, there only remains prevention. The prevention of tuberculosis or of malaria might have become an insoluble problem, had there been a premium on each new person that fell ill, had each new case meant money to the person who infected him. Yet this is what happens with drug addiction. The peddler at one end creates the market, the manufacturer at the other keeps up the supplies, and it is the huge profit accruing to a long chain of individuals which makes for the spread of this preventable disease called addiction. Fortunately, there was no money in spreading tuberculosis, otherwise there might have been a different tale to tell, but it seems a pity to save people from an assortment of infectious diseases, only to hand them over to something more ruinous. In Detroit, for example, one is told that there are at present 10,000 drug addicts. One would make quite a fuss over 10,000 cases of cholera in a community.

The number of addicts in America is variously estimated all the way

from 250,000 to a million. Being a secret habit, and not recognisable till the patient is down and out, these estimates can only be the merest guesses. There are no accurate statistics. Mr. Porter, Chairman of the Foreign Affairs Committee of the House of Representatives, estimates that the economic loss through addiction amounts to a billion dollars a year. This includes loss of earning capacity; the destruction of property due to robberies and hold-ups; the maintaining of narcotic police squads; costs of trials and conviction of peddlers and smugglers, and the upkeep of prisons and other institutions. Quite a sum, for a preventable and unnecessary disease.

The root cause of the problem is over-production of opium. For over a century, opium has been a most profitable moneymaker in the Far East. Colonial governments sell opium in licensed shops and earn a handsome revenue in this way. Thus, there are the authority and sanction of great and influential nations supporting the traffic. A nation that licenses opium shops and smoking divans in the Far East, cannot be expected to frown upon its drug manufacturers who turn out morphine and heroin—turn them out for exactly the same purpose for which opium shops are licensed—to make money. Only, the opium shops are established by law and the sales are legitimate; drugs for addiction are sold surreptitiously, a nice moral distinction.

Statistics as to the production of opium are not easy to ascertain. Big gaps occur, and there is no enthusiasm for filling them in. This shyness about statistics is perhaps the first indication of a turn for the better. It indicates fear of public opinion. Theoretically, all countries are supposed to make annual reports to the League of Nations. Practically, the reports are late in arriving—sometimes don't arrive at all—and are often incomplete. These figures from the principal producing countries are for 1926:

| | |
|---|---|
| Serbia | 102 tons |
| Turkey | 886 " |
| Persia | 956 " |
| India | 869 " |

Opium is also grown in small amounts in Hungary, Greece, Korea, Afghanistan, etc., but this only amounts to 1 per cent of the total raised in the chief producing countries. In addition, there is China, but for China there are no figures at all, for poppy-growing is contraband. Undoubtedly the amount is huge; some authorities think it equals or surpasses that of India. It is of a poor grade, however, and is used for smoking, not for the manufacture of drugs. There is a strong anti-opium sentiment in China, and when once that country is stabilised, there is every hope that poppy-growing will be completely stamped out.

The bulk of the world's opium is used for smoking. This goes on in the British colonies of the Straits Settlements, Hong Kong, the Federated Malay States, the Unfederated Malay States, Sarawak, Brunei and British North Borneo. All told, opium yields about 25 per cent of the total revenue of these colonies.

There is also the French colony of Indo-China, where smoking brings in 15 per cent of the revenue. In the Netherlands East Indies it brings in about 5 per cent.

After the smokers are supplied, the remainder of the opium goes into the world's factories, to be made into drugs. The drug-making countries are few, but amongst the most highly civilised and enlightened in the world, namely, Great Britain, France, Holland, Germany, Switzerland, Japan

and the United States. Again, statistics are difficult to obtain. The countries are not always frank. There are many devious and ingenious ways of hiding the actual manufacture. Holland flatly refuses to give figures. France gives an "approximate" estimate. The United States reports "manufacturers' sales," not actual manufacture. Furthermore, a great deal of morphine is turned into innocuous substances called esters (morphine treated with an acid) and these morphine-esters are not recorded at all. For trade purposes they are not considered morphine, and so are shipped freely all over the world. Once arrived at their destination, the acid is removed by a cheap and easy process, and the purchaser has so much pure morphine to slip into the illicit trade. These morphine-esters are without limit—each with a different chemical formula and terrific names, and a new one comes on to the market every month. They constitute a most serious danger.

These figures show the manufacture of morphine:

| | *1926* (kilograms) | *1927* (kilograms) |
|---|---|---|
| Germany | 20,700 | 12,800 |
| France | 2,000 | 2,300 |
| Great Britain | 5,762 | 5,230 |
| India | 1,977 | 156 |
| Japan | 1,640 | 1,807 |
| Switzerland | 8,000 | 3,757 |
| U. S. A. | 2,998 | 2,971 |

1,000 kilograms is approximately 1 ton

In addition to morphine, there is a large output of heroin and codeine. All the countries are now busily making codeine which, like the esters, can be shipped freely, without restrictions. Codeine can be turned into two powerful drugs of addiction. It is interesting to note that while codeine is considered "harmless" when shipped by the ton, most countries govern its retail sales by the same restrictions that apply to morphine.

These tables give an incomplete picture of the world's manufacture for the past two years:

| | *1926* | *1927* |
|---|---|---|
| Morphine | 13,315 kilos | 7,466 kilos |
| Heroin, etc. | 6,143 " | 3,888 " |
| Codeine, etc. | 19,643 " | 12,879 " |

These figures do not include the codeine made in the United States—4 tons were made in 1928. The statistics are very incomplete. How much morphine was used in making esters, is an unanswered question. It is amazingly difficult to obtain information. Hungary, for example, has just set up a drug factory which produces morphine 50 per cent cheaper than the usual process. Persia has just established a factory. At every meeting of the Opium Committee in Geneva, news of these recent establishments filters in, yet nothing happens. For so many years the important countries have refused to curtail their output, that these little countries are stimulated to take a hand in the game and a share in the profits. Yet all these countries are bound by an international agreement, the Hague Opium Convention of 1912, to limit manufacture to medicinal needs. The Geneva Convention of 1925 repeats that obligation, but no one attempts to fulfil it. There is no public opinion, hence this huge overmanufacture of drugs, which exceeds the medical needs of the world as 10 to 1. But there is no money in medical use, no money in an eighth of a grain of morphine after an appendix operation. No, the big money comes through supplying the addict with his 30 grains a day.

This business of drug manufacture is in the hands of private individuals. It is unlike the sale of smoking opium in the Far East, which brings direct revenue to colonial governments. But

these private individuals—manufacturers, wholesale dealers, importers, exporters and middlemen of all kinds—evidently form an influential minority in the countries where they reside. It is obvious that these commercial interests are able to exert pressure upon their various governments and this pressure has successfully withstood all efforts to curb the traffic. Production of raw material goes on flourishing and drug manufacture is unlimited. Efforts made at Geneva by members of the Opium Committee (divided into a pro-opium and an anti-opium faction) have accomplished little or nothing, but what Geneva has done has been to afford publicity.

Thanks to this publicity, light has been shed upon every phase of this notorious traffic. Each year the evidence has piled higher and higher, showing its extent and ramifications, and the tricks and dodges which enable it to continue. We are able to see which influential countries are blocking the game, and which are fighting for improvement.

The United States claims to have limited its drug manufacture to medical needs. To this end, a Federal Narcotics Control Board was established in 1924, consisting of the Secretary of State, of Commerce and of the Treasury. This Board was to limit the imports of raw opium, so that we could make enough drugs for our strict medical needs. This limitation has been curious. Thus:

| | | | |
|---|---|---|---|
| 1921 ... | 47,024 | pounds or about | 23½ tons |
| 1922 ... | 135,093 | " | 67 " |
| 1923 ... | 99,353 | " | 49 " |
| 1924 ... | 87,343 | " | 43 " |
| 1925 ... | 100,478 | " | 50 " |
| 1926 ... | 107,747 | " | 53 " |
| 1927 ... | 142,139 | " | 70 " |
| 1928 ... | 140,172 | " | 70 " |

The medical needs of this country seem never to have been ascertained. In 1928, the legal sales of drugs consisted of 3 tons of morphine and 4 tons of codeine. One wonders what proportion of this was used in the treatment of addiction? No answer seems to be forthcoming.

Our per capita consumption is very high. The League of Nations has set a standard, giving 7 grains of opium per capita as a reasonable amount. Our per capita consumption is 10 grains. This has been our average annual consumption for the past five years. Ten grains of opium equals one grain of morphine, and it seems a bit steep to realise that our *legal consumption* has reached this height.

What we receive through illicit channels, heaven alone knows. The international smugglers who bring drugs into this country, join with the worst elements in our own country to accomplish their purpose. Every day we read of drugs seised by the police. Nor is it reassuring to know that the seisures represent only a tenth part of the contraband in transit. But at least we might know what becomes of the drugs that are seised? Are they destroyed? If not, what becomes of them? How are they disposed of? Are they sold again and, if so, to whom? There are many things in this country which need an explanation.

An effort has been made to ascribe drug addiction in America to prohibition. This is hardly correct, since addiction exists all over the world, in countries where liquor is sold freely. In Germany, for example, addiction has increased over 100 per cent in the last six or eight years. No, this increase in drug-taking is due solely to the excessive and superfluous manufacture of drugs. The only remedy for this grave situation which exists, not only in our own country but throughout the world, is an enlightened public opinion, for the problem, like the danger, is international.

# A Means of Stimulating the Student Nurses' Interest in Chemistry

LOULA E. KENNEDY *and* JOHN C. KRANTZ, JR.

BENJAMIN HARROW divides the history of chemistry into four periods. The first, or foundation period, is associated with the name of Lavoisier; the second, or classification period, is illuminated by the name of Mendeleeff; the third, or physico-chemical period, bespeaks the name of Svante Arrhenius; and the fourth is the period of radio-activity, in which the name of Mme. Curie predominates. We are now launched upon a fifth period in the development of chemistry, which may be fittingly regarded as the period of supremacy of chemistry among the physical and biological sciences. The placing of the practice of medicine upon a sound scientific basis has been the means of demonstrating the important rôle that chemistry plays in health and disease. With the increasing requirements for chemical education on the part of schools of medicine, the profession of nursing, in order to adequately maintain its unique position as a profession ancillary to the practice of medicine, had to acquaint its students with the fundamentals of chemistry and with that science as it is applied to its own profession.

### *The Place of Chemistry in the Nursing Curriculum*

IN the probation period, the time recommended for the study of chemistry is forty-five hours arranged in one-and-a-half hour periods to include lecture, recitation, and laboratory work. Anyone familiar with the science of chemistry and the illimitable nature of its scope knows that in the short period of time allotted to this subject one can barely scratch the surface of its fundamentals. When we consider it as the science which deals with the structure of matter and that upon it the sciences of bacteriology, pathology and physiology are definitely dependent, even the most conservative would agree that this is not ample time for this subject. Furthermore, the work which the nurse is called upon to do in the administration of medicine involves a knowledge of chemical and therapeutic incompatibility which is not usually covered in the courses of materia medica and pharmacy included in the nursing curricula. For the purpose of safeguarding the patient, and in the interest of public health, it is imperative that the modern nurse be instructed and well-grounded in the chemistry of medicinal products.

### *The Teaching Problem*

IN an Arts and Science College, the phases of chemistry with which the nurse is expected to become familiar are covered in a period of approximately two years including, roughly, one hundred twenty-eight lecture hours, and one hundred twenty-eight three-hour laboratory periods. (This of course would vary with the institution in which the course is given.) The nurse is expected to grasp this material in forty-five hours. This condition exists even though it is more important for a nurse to be able to distinguish between calomel and bichloride of mercury than it is for students of science and arts who will possibly never see or handle either one of these products after they leave the chemical laboratory. With so much

material to cover and so short a period in which to teach chemistry, the problem of proper elimination of comparatively unimportant material from the course becomes as imperative as the proper selection of the material to be included. The second author has, for the past five or six years, given twenty-five lectures and fifteen one-and-one-quarter hours laboratory periods in chemistry to the nurses in the Training School of the Johns Hopkins Hospital. The instruction has included the fundamentals of chemistry, certain non-metals and metals, the important organic compounds, a conception of the field of organic chemistry, and five lectures on the chemistry of digestion and metabolism. The laboratory instruction is outlined so as to supplement the didactic portion of the course. Our experience has been that in the effort which the nurse is making to grasp the many details of the science in this short period of time, she loses, in a large measure, a general conception of the service which chemistry renders to medicine and nursing and hence there is a lack of interest.

### *A Stimulus*

OUR first step to increase the enthusiasm of the nurse in the science of chemistry was to have prepared a large poster which greets the student nurse each time she enters the chemistry lecture hall. This poster, which is illustrated, deals with the presence of the science of chemistry in every phase of the life of the nurse. The wording of the typical poster accompanying may be found helpful to the reader.

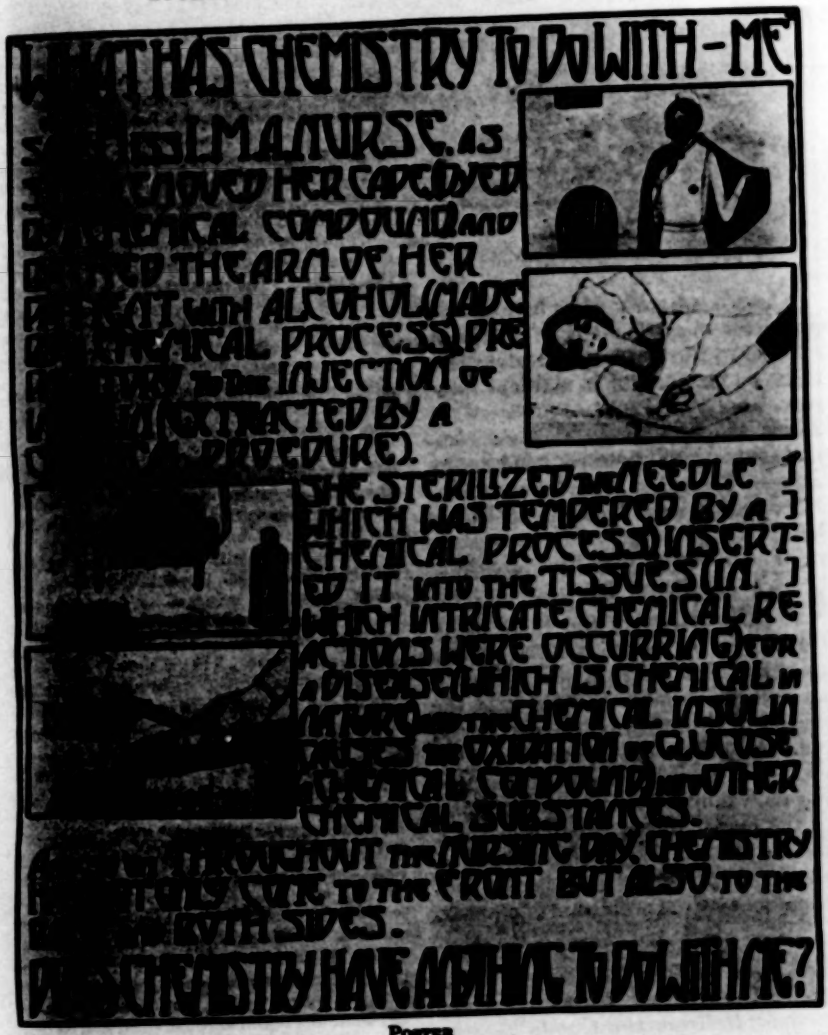
### *The Prize Essay Contest*

MR. AND MRS. P. GARVAN of New York City, as a memorial to their daughter, Patricia, have given a sum of money for the purpose of stimulating the interest of secondary and college students in chemistry. This essay contest is conducted under the auspices of the American Chemical Society. Six prizes of $500, six prizes of $300, and six prizes of $200 are offered to Freshmen students of colleges and universities in the United States who write the first, second, and third best essays. The prizes are valuable and of sufficient importance to warrant the student's making every effort to be the recipient of one of them. There are six subjects:

1. The Relation of Chemistry to Health and Disease.
2. The Relation of Chemistry to the Enrichment of Life.
3. The Relation of Chemistry to Agriculture or to Forestry.
4. The Relation of Chemistry to National Defense.
5. The Relation of Chemistry to the Home.
6. The Relation of Chemistry to the Development of an Industry or a Resource of the United States.

Any modification of these subjects may be used by any of the contestants. Thus the student nurses who are high school graduates would compete with the college Freshmen, and would likely select a title which is most closely related to their work. The books available for reference for the various students can be obtained easily from any library of science or medicine.

In introducing the essay contest into the course, the present authors required each student to write an essay which would constitute 25 per cent of the mark of the student. All of these essays were graded very carefully and the six best were forwarded to the State Chairman of the American Chemical Society for the purpose of having these entered in the contest.


WHAT HAS CHEMISTRY TO DO WITH-ME
I AM A NURSE. AS
INJECTION OF
THE STERILIZED NEEDLE
WHICH WAS TEMPERED BY A
CHEMICAL PROCESS I INSERT-
ED IT INTO THE TISSUES (FAT)
WHICH INTRICATE CHEMICAL RE-
ACTIONS WERE OCCURRING FOR
THE CHEMICAL INSULIN
CAUSES THE OXIDATION OF GLUCOSE
OTHER
CHEMICAL SUBSTANCES.
THROUGHOUT THE NURSING DAY CHEMISTRY
TO THE FRONT BUT ALSO TO THE
BOTH SIDES.
HAVE ANYTHING TO DO WITH ME?

Poster

The one of the six which was deemed best, was read before the class without the name of the student being announced, in order that the worst might have the opportunity to hear how the best student had written her essay. After the reading of the essay, the name of the student was announced and a copy of "Chemistry in Medicine" was presented to her as a mark of distinction for having achieved the goal of writing the best essay on chemistry. The students were allowed to choose their own topics, and the analysis of the titles selected by them is interesting indeed.

| No. | Title |
|---|---|
| 10 | Relation of Chemistry to Health and Disease |
| 10 | " " " " Enrichment of Life |
| 9 | " " " " the Home |
| 4 | " " " " Medicine |
| 3 | " " " " the Nurse |
| 2 | " " " " Nutrition |
| 2 | " " " " National Defense |
| 1 | " " " " Every Day Life |
| 1 | " " " " the Kitchen |
| 1 | " " " " the Rubber Industry |
| 1 | " " " " Synthetic Research |
| 1 | " " " " Sugar |
| 1 | " " " " Petroleum |
| 1 | " " " " Agriculture |
| 47 | |

The second author has had the opportunity to grade many of the essays entered in the contest by various students and in his opinion many of those submitted by the student nurses of the Johns Hopkins Hospital were commensurate with those handed in by college Freshmen from the various Universities and Colleges of Maryland.

### *Conclusions*

OUR experience has been that the participation in the Prize Essay Contest by the members of the nursing class has been a means of stimulating an unusual amount of interest in the science of chemistry on the part of the student nurse. Furthermore, this exercise has been invaluable in enhancing the value of chemistry in the mind of the nurse, and in creating in her a mental vision of the importance of chemistry in health and disease and consequently the profession of nursing.

## *A Good Nurse "Delivers the Goods"*

MUCH has been said regarding the nurse's ability to get results, both in the sick room and in the public health field. In many places she has the job to do almost alone, with the doctor to advise only as to the general policy to pursue; but in many cases few details can be given in the limited time of his visit.

What *is* it she does which brings the results? I think I've found out, and the secret *is* simply this. She not only plans her work, but she works her plan on a definite schedule which she dispatches with the system of a train dispatcher in a big railroad station. For example, the public health nurse finds a sick person and calls the doctor who comes and prescribes diet, hygiene, and possibly medicine, and then leaves. The bedside nurse notes his directions, plans and schedules the program outlined, and carries it out with precision. Nothing is left to chance. All goes like clockwork, because it goes by the clock. There is little hesitation, little or no quibbling, no missing, and rarely any permanent ill feeling on the part of the patient. He may start to object and think he will flatly refuse to take orders, but he will soon do everything and like it, because he will see the benefits to be derived through his cooperation.

In the public health field, a child's eyesight is found to be defective by the school physician, and the parents' attention is called to the fact by the school nurse who visits the home for that purpose. The parent promises to consult an oculist about the further examination and correction of the child's eyes, but she is busy and doesn't do so. Back comes the nurse, and this time she asks the mother for the name of her physician, looks up his office hours and arranges an appointment. On the appointed day we see the nurse back in the home in time to see that the mother keeps the appointment. The doctor's advice is carried out under her supervision until the mother can acquire sufficient technic to assure results. If for any good reason the parent can't take the child for examination or treatment, the nurse takes her place and goes to the doctor with the child. That is service that gets results. She not only takes the order, but she "delivers the goods."

The nurse recognizes the important fact that when one has many duties and problems to meet, the most urgent need should receive attention first. I have seen a nurse go to a home to urge the parent to consider the advice of her doctor and allow her child to have his tonsils removed before complications appeared, but on her arrival at the home she found another child sick in bed. The nurse quickly realized that the child in bed with fever was in more urgent need of her help at that time than the child with defective tonsils; and she gave her whole attention to the acutely ill child, got the doctor on the case promptly, and won the mother's admiration and friendship. The tonsils were discussed at a later time, and the mother readily consented to the nurse's suggestion to follow the doctor's advice about removal of the tonsils."—LeRoy A. Wilkes, M.D., in *Child Health Bulletin*, May, 1929.

# The Student Nurse in the Out-Patient Department

MYRTLE M. HOLLO, Ph.B., R.N.

AT the American Hospital Convention, held in Minneapolis in October 1927, Dr. Hugh Cabot made the statement that if he had to choose between the hospital and the out-patient department, as a teaching field for the medical student, he would choose the out-patient department. For many years the medical profession has utilised the teaching facilities of the dispensary, but educators of nurses have, with comparatively few exceptions, completely failed to realise the unlimited opportunities for teaching which the out-patient department presents.

Perfection of nursing technic may be acquired in the hospital ward, but since the great public health movement has opened wide the gates of opportunity for the nurse, and the bedside is no longer her only sphere of service, it must be granted that the out-patient department has something to contribute toward the education of the student that the hospital is unable to give. The curative function of the hospital is gradually being supplemented with the modern program of preventive medicine, but as yet the out-patient department, in that it reaches a greater number of individuals, seems to be the logical field for the beginning of teaching positive health and the prevention of disease. By encouraging periodic health examinations, we are going to reach the individual before the invasion of disease.

Dr. Dewey defines the aim of education to be "to develop in the individual, continued capacity for growth."

Dr. W. W. Charters gives this definition: "The aim of education is to give the individual an appreciation and control of life values." Varied, indeed, are opinions of just what education should do, but it must be conceded that education should fit the individual for better citizenship, better health, practical efficiency and worth-while use of leisure time.

Since we no longer speak of the *training* of the nurse, but rather of her education, it is timely that we utilize every opportunity for furthering her education, of stimulating the realization of her responsibility to herself and the community.

The patient in the hospital may often be viewed in the more or less unnatural social atmosphere that hospital environment creates, but in the dispensary we are afforded the opportunity of studying many more individuals against the natural background of their own social environment.

While the out-patient department has, during the past few years, been gradually emerging from its place as "the Cinderella of the Hospital Household" to a more or less well recognized place in the community, it is still often very difficult to impress hospital executives and nursing educators with the importance of its worth as a teaching field for the student nurse.

It was in 1879, in New York City, that a graduate nurse was first employed in a dispensary. During this fifty years, little thought has been given to what benefit the nurse might be able to derive from her dispensary experience; rather were they concerned with what service might be given in assisting the clinician and patient. At times individual nurses have attempted to point out the opportunities the dispensary affords for

studying community needs, but it was not until the Rockefeller Report in 1923, that the dispensary was given its true evaluation as a field for the teaching of the student nurse.

Under the existing conditions, which are far from ideal, we have attempted to outline a program of instruction for our students whose length of service in the out-patient department is limited to one month.

The methods of teaching are:

1. Group teaching—daily morning conferences for one-half hour.
2. Individual instruction and demonstration in the clinic by the nursing supervisors.
3. The case-study method.

The immediate aims of this instruction are:

1. To teach the student, clinic management.
2. To teach her to adapt her nursing skill to the needs of the ambulatory patient.
3. To teach her the technic of the various treatments carried out in the clinics, thereby enabling her to render more efficient assistance to the clinician which will mean better care of the patient.
4. To teach her to recognize the importance of periodic health examinations in bringing about the early recognition and treatment of disease.
5. To teach the student to evaluate the social and economic aspects of disease and to study the patient from this viewpoint.
6. To call her attention to the unusual clinical cases rarely found in hospital wards.
7. To emphasize the importance of follow-up work of hospital cases admitted to the dispensary, and the follow-up of dispensary cases admitted to the hospital.
8. To acquaint the student with the work of the social service department and to evaluate the importance of cooperation between this and the nursing profession.
9. To familiarize the student with the organizations in the community which have for their object the social welfare of the individual and the improvement of the community in general.
10. To provide a personal contact with the student nurse and the health worker who may bring the patient to clinic.

Indirectly in our teaching we aim:

1. To bring home to the student her definite responsibility in the community health program.
2. To stimulate her with a desire to teach positive health.
3. To impress upon her the importance of maintaining a high standard of personal health, thereby proving to others the effectiveness of her teaching.
4. To evaluate the importance of the contact gained by rendering nursing care and teaching health simultaneously.
5. To point out to the student the new attitude taken by the medical profession in the modern health program. The ancient spirit of secrecy regarding medical practice is no longer in vogue. The patient is taken into the confidence of the clinician and helps in the diagnosis and treatment of his case. Teaching the tuberculous patient to keep his own temperature records and the diabetic to make urinalyses, are striking examples of this.
6. To guide the student in a course of study that will promote her own education and enable her to recognize the community needs and her responsibility in assisting to solve the problems encountered in meeting these needs.

The course of study to be carried out in the morning conference may be outlined as follows. The student will be given this outline and will be required to read the assignments that will prepare her for a clearer understanding of the subjects to be discussed.

FIRST WEEK

Monday—

I. The Dispensary:
   1. Diagram of our organization.
   2. Brief historical résumé.
   3. Nursing services in dispensaries new and old.
   4. Types of Patients. Eligibility.
   5. Fees and their importance in creating a spirit of self-respect in the patient.
   6. The place the out-patient department holds in the modern health program.

II. Tour of the Department:
   1. Admitting office.
   2. Record office.
   3. The clinical record. Importance of social history.

4. Forms and blanks—application to hospital, etc.

*Required Reading:*

"Dispensaries," Davis and Warner.
"Clinic Hospitals and Health Centers," Davis.
"Nursing and Nursing Education," pages 330–347, Goldmark.

Tuesday—

I. Clinic Management:

1. Opportunities for learning to deal with groups of people.
2. Importance of the early recognition of symptoms of infectious diseases and isolation of such patients.
3. Importance of caring immediately for the more seriously ill patient and thereby "speeding up" his treatment which may include hospitalization.
4. The importance of following up the treatment of the dispensary patients in the hospital, and the former hospital patients in the dispensary.
5. Importance of gaining the patient's confidence—making a good first contact in the out-patient department, as this may greatly affect the patient's impression of the hospital and its personnel.
6. Value of a knowledge of psychology.

*Reading:*

"A Text Book for Nurses," Muse.
"Psychology in Its Application to Today's Work," Faber, *A. J. N.*, June, 1925.

Wednesday—

I. Health Education:

1. Freedom from disease should not be our standard, health positive not negative. We should feel the joy of living.
2. Sanitation.
3. Personal Hygiene.

*Reading:*

"Hygiene and Sanitation," Williams.
"The New Hygiene," Hill.
"Personal Hygiene Applied," Williams

Thursday—

I. The Social and Economic aspects of Disease:

1. The family as the unit of society.
2. Economic factors which have influenced the modern health movement.
   (a) The industrial revolution.
   (b) Migration from rural to city communities. Housing in apartments.
   (c) Immigration.
   (d) Unemployment. What is a living wage?

*Reading:*

"Social Work a Family Builder," Townsend.

Friday—

I. Mental Hygiene:

1. Brief history of the movement.
2. Importance to the nurse in dealing with patients and in interpreting the problems of her own life.

*Reading:*

"Mental Hygiene and the Student Nurse," Richards, *A. J. N.*, Feb., 1928.
"Mental Hygiene and the Public Health Nurse," MacDonald.

Saturday—

I. Instruction on Case Study:

1. Outline merely a guide.
2. Stress the social aspects of the case rather than the medical.
3. Use tact in inquiring, never embarrass the patient by too personal questions.
4. Indirect questioning more effective.

*Reading:*

"Case Study," McLurg, *A. J. N.*, June, 1928.
"The Pupil Nurse in the Out-Patient Department," N. L. N. E., 1925. Case Studies.

SECOND WEEK

Monday—

I. Social Service Conference with Director of Social Service Department.

Tuesday—

I. Prenatal Care:

1. Opportunities for positive health teaching afforded by this clinic.
2. Aims. What is meant by maternal death rate? Infant death rate?
3. What does the program include? The part of the nurse, the physician.

*Reading:*

Pamphlets and letters.
Minnesota Child Hygiene Division.
Routine and Briefs for Mother Club Talks, N. Y. Maternity Center.

Wednesday—

I. Prenatal Care, continued:

1. Social aspects of maternity and infancy.
2. Women employed—effect on maternity.
3. The unmarried mother—local agencies that provide assistance to her.
4. The illegitimate child, a ward of the state.
5. Length of time law requires mother to nurse her baby. Free hospitalization of unmarried mothers at time of delivery—at University. State Board of Control.
6. Mothers' pensions—one form of preventive social work.

Thursday—

I. Dental Hygiene—Demonstration given by Dental Clinic nurse.

Friday—

I. Report of Case Studies by Students in Prenatal Clinic.

Saturday—

I. Informal Discussion of Clinic Problems of the week. Each student is to report on concrete examples of her health teaching in the Clinics.

THIRD WEEK

Monday—

I. Demonstration by Child Hygiene Division Nurse.

Tuesday—

I. Child Care and Child Training:

The opportunities the pediatric clinic affords for the observation of the development of the normal child, the abnormal child.
Tables, rules and standards merely guideposts.
Why it is important to know the average rate of increase of weight in the normal child, the eruption of teeth, etc.?
Immunization program, teaching the parents its importance.
Importance of health habits for children.
Regularity, obedience, industry and consideration for others.
The nurse's responsibility in the education of parents regarding care and training.
Behavior problems—treatment in the clinic.
The child guidance clinic a means of preventing juvenile delinquency.

*Reading:*

"Mental Hygiene—Work with the Pre-School Child," Peck, *P. H. Nurse*, 1926.
National Committee for Mental Hygiene, "Points on Child Behavior and Pertinent Points for Parents."
"Every-day Problems of the Every-day Child."
Minneapolis Infant Welfare Society Pamphlet, "Your Child."
Thom, "Habit Training, Child Management, Every-day Problems of the Every-day Child."
"Current Immunization," A. P. H., Nov., 1926.

Wednesday—

I. Nutrition Clinics:

1. How the movement began—outgrowth of war. Startling facts the Army and Navy gave out regarding the lack of physical fitness of American manhood.
2. Malnutrition—not to be associated with the poor child only.
3. Importance of teaching parents the values of foods.

*Reading:*

Pamphlets by Children's Bureau.
Pamphlets, American Child Health Association.
Visual education—posters.

Thursday—

I. Posture Clinic:

1. Talk on Posture by clinician in orthopedic clinic.
2. The crippled child, and community agencies providing care and treatment.

*Reading:*

Government pamphlets, "Posture Clinics," "Posture Exercises."

Friday—

I. Skin Diseases and Disorders:

1. Evaluation in the public health program.
2. Knowledge of symptoms necessary for all nurses and especially the school nurse.

Saturday—

I. Report of Case Studies by Students in Pediatric Clinic.

II. Examples of Health Teaching by Use of Posters by Each Student.

### Fourth Week

Monday—

I. Social Service Conference.

Tuesday—

I. The Surgical Clinic:

1. As a field of preparation for industrial Nursing.
2. Emergency cases—accidents occurring while employed—accident insurance and compensation. Laws regulating and providing for the safety of the operator of machinery.
3. Varicose vein treatments. Great economic saving to patient in this method of treatment.
4. Report of case study dealing with this treatment.

Wednesday—

I. The Venereal Diseases:

1. The out-patient clinic as a field for studying social hygiene.
2. Importance of sex education.

*Reading:*

"Social Hygiene," Stokes, *A. J. N.*, 1924.

"Sex Education," Bigelow.

Thursday—

I. The Medical Clinic:

1. Gastrointestinal, cardiac, diabetic and tuberculosis clinics.
2. The vital problems of each and the teaching of positive health that each clinic affords.

Friday—

I. Public Health Nursing:

1. Every nurse a public health nurse.
2. To think in terms of health rather than disease.
3. The out-patient department affords many opportunities of bringing the student in closer contact with public health nursing and her definite responsibility toward the community.
4. History and development—brief résumé. Fundamental principles.

*Reading:*

"Public Health Nursing," Gardner.

"Manual of Public Health Nursing."

Saturday—

I. Resources:

1. Relation of the University Out-Patient Department to the community.
   Diagram of the organization.
2. State institutions.
   Student should have a clear understanding of the nature and location of each. a. Diagram of organization of State Board of Health.

*Reading:*

"Community Health Organization," Am. P. H. A., 1927.

### Fifth Week

Monday—

I. Case Studies and Reports.

Each student is required to write two case studies during the month and at the close of her service a report, "Impressions of My Out-patient Service."

This report is especially valuable not only to the student in that it teaches her to classify her experiences and evaluate their worth, but also to the supervisor as an aid in ascertaining how effective has been her teaching.

While this program may cover a field that seems too extensive to be of value, it is an attempt to correlate the theory with the practical and furnish food for thought and help, as the student meets the problems in the various departments of the dispensary. An interrupted service where the student is assigned to a shorter term, following her service in each hospital department, may have its advantages,

but a continuous service, rotating in the various clinics, gives the student a much clearer picture of the institution as a whole, and when given in the Senior year may serve to give a valuable summary or review of the various hospital services. If given in the Junior year, the student should gain a keener appreciation of the problems to be met in her remaining months of hospital work. It should give her an insight into public health nursing and may be a valuable field for vocational guidance.

Most of the students are in a very receptive mood, they have the stimulation that a new experience brings to them and are very interested and eager to learn. They are in an environment that should further their desire to learn, for here at the University Dispensary the clinicians teach the medical students not only in the lecture rooms but in smaller groups in the clinic rooms and the student nurses have the opportunity of "listening in" on this valuable teaching.

A students' reference library in the dispensary building would do much in furthering the cause of education. This at the present time is somewhat limited, but we do find much valuable material in the patients' records, and the students are encouraged in the use of these.

The students' case studies and reports are kept on file and we aim to put the most valuable of these into some form that may be made accessible to future students. If our profession is to grow we must further the growth of every member and the individual efforts of the student should be recognised and evaluated. Too often has the mental growth of the student nurse been dwarfed by the excess of physical strain in hospital wards.

We all need stimulation—spiritually, mentally and physically—but each in a corresponding ratio to the make-up of the individual. Her contribution of service to the community will be measured by the worth of her own life.

### *Plastic Wood for Teaching Models*

THOSE who have worked in modeling clay, plasticine, wax, plaster and papier-maché, have had models cast in metal or paper or in the glue that plaster workers use, can appreciate the good and bad points of each. A new material is available for those who believe in teaching in three dimensions, one that promises to furnish more good points for models than any other single substance.

Plastic wood is a kind of wood pulp of the consistency of putty or thick paste, according to the amount of vehicle worked into it. It molds like clay, cuts like plaster, whittles like wood and hardens like iron. A liquid is provided for thinning the soft mass if desired. Its only drawbacks are quick setting, the need of building up in layers for thick models, and the cost as compared with plaster or clay. It has none of the chipping defects of plaster or papier-maché, though it is as light as the latter; it does not split like wood, and there is a stage when it can be cut like cheese. Also, it is readily filed, sandpapered, polished, painted and varnished. In constructing parts that are very thin and unsupported—for instance, in making the life-size internal pelvic organs of the female—one runs a flexible wire inside the utero-ovarian ligament or the tube, if these are shown independent of the broad ligament. Nails and screws hold well. A uterus, for example, is sawed in two and then hinged to open in demonstrating the cavity or a pregnancy or a polyp. Besides the wood-colored pulp there is a white substance, or "the cement."

The material is made by the Addison Leslie Company of Canton, Mass. It comes in tin cans, 25 cents for a small can, or a dollar a pound, the cost being reduced proportionately for larger quantities. Hardware and art-supply stores often have it on sale.—Robert L. Dickinson, M.D. The *Journal of the American Medical Association*, Chicago, Ill., May 4, 1929.

# New Technic for Catheterization of Women

## *In Use at Johns Hopkins Hospital, Baltimore, Md.*

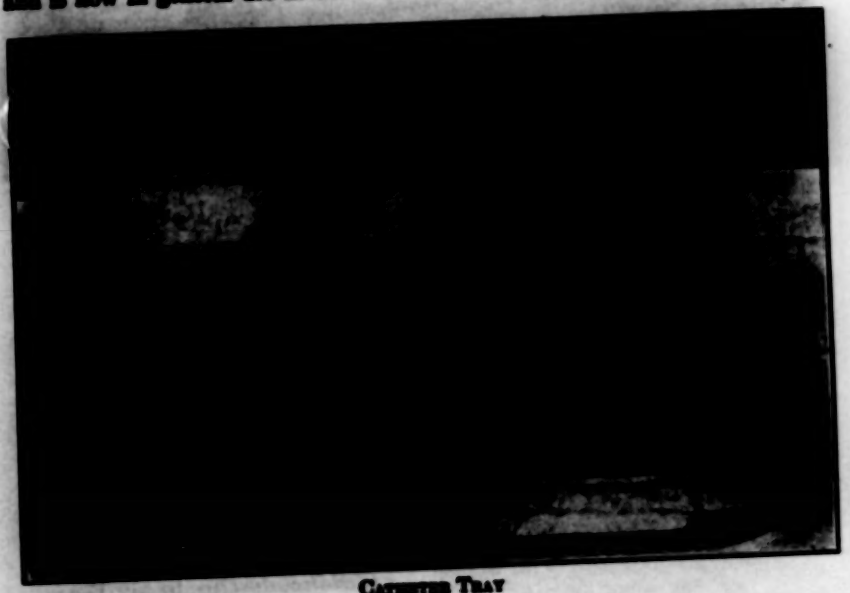
WINIFRED PATRICK, R.N.

THE new technic for catheterization of women was suggested by the gynecological staff of the Johns Hopkins Hospital after having been used satisfactorily in the gynecological out-patient department. It was approved by the other services and is now in general use in the hospital. The purpose was to further simplify the procedure.

In comparing the new method with those of elaborate technic, one is impressed by the simplicity of the equipment, preparation, and procedure.

### *Technic for Routine Bladder Catheterization*

a. Equipment
   1. Deep enamel tray
      1. Jar sterile dry toothpick swabs.
      2. Jar sterile dry pledgets.[1]
      3. Sterile glass catheters (two), rubber tips (boiled in large covered basin).
      4. Sterile forceps (boiled in small covered basin).
      5. Sterile finger cots (boiled in basin with forceps).
      6. Glass funnel and tubing with pointed nozzle attached (boiled in basin with catheters).[1]



CATHETER TRAY

      7. Medicine glass (boiled in basin with catheters).[1]
      8. Lavatory towel, dressing rubber (to protect bed).
      9. Enamel bowl (for the collection of urine).
      10. Enamel bowl (for used toothpick swabs).
      11. Sterile olive oil.
      12. Merurochrome 5 per cent aqueous solution.
      13. Sheet.
      14. Light.
      15. Silver nitrate 1-1000.[1]

[1] Used when giving bladder instillation only.

Catheters That Ready for Use

b. Procedure
1. Patient on back with knees flexed, protected by draw sheet.
2. Protect bed.
3. Arrange articles to be used.
4. Use forceps—place two or three sterile toothpick swabs upright against side of sterile basin in which forceps were boiled.
5. Cots on thumb and first finger of left hand.
6. Spread labia wide.
7. Sight meatus.
8. Saturate swab with mercurochrome solution by dipping swab into container of solution.
9. Apply mercurochrome to the meatus and surrounding tissues so that an area two centimeters in diameter has been treated.
10. Discard first swab and repeat the process with the second.
11. Catheter—grasp by rubber end, dip in the sterile olive oil, and insert gently into meatus, never use force.
12. Empty bladder of urine, collecting in enamel bowl.
13. Remove catheter as follows, pinch the rubber tubing tightly, so that no air can rush into the bladder, and then withdraw gently.
14. Clean articles—stock tray.
15. Chart catheterization.
16. *Precaution*—when collecting sterile catheterized specimens of urine, it is important to collect 20-25 cc. of the last portion of the flow. If the first portion is taken there may be enough mercurochrome present to inhibit the growth of bacterial organisms, which it may be desirable to find.

## *Out of Babyhood into Childhood—One to Six Years*

THIS interesting material is put out in readily usable form. The subject is discussed under the following headings:

| | |
|---|---|
| No Longer a Baby | Food Habits |
| Habits | Diet |
| Play | A Daily Food Plan |
| Sleep and Rest | Keeping the Well Child Well |
| Cleanliness | Is Your Child Ready for School? |
| Clothing | The Healthy Child |

—Folder No. 10, United States Department of Labor, Children's Bureau, 1920.

# Nursing Progress in France

L. CHAPTAL

UNDER this title, we do not mean to make a general review of the work done in our country on any specialized line. We shall refer those amongst our readers who are interested in Public Health Nursing to our paper on "Public Health and Social Service in France from 1900".[1] Our aim in the present lines is more directed towards progress in nursing "as a profession" and can be put under two headings:

I. Progress in Nursing Education.
II. Progress in Professional Organization.

## I

### *Progress in Nursing Education*

IN 1922, a decree was passed which gave a statute to nursing in France. This inaugurated a new era and was the nucleus around which focussed all nursing progress.

As regards education, the decree established a two-year curriculum for hospital training and three years with public health included. Training schools were allowed to prepare candidates for a state diploma, provided they fulfilled the requirements as to the adopted curriculum: practical and theoretical training, including ethics of nursing; length of training, age of pupils (20 to 35 years); their previous education, high school with at least one university degree, etc. . . . Examinations were to be passed before a jury nominated by the Ministry of Health and numbering at least eight members among whom one or more delegates elected by the schools of nursing and at least one matron and one nurse actually in practice.

At the same time, a Board called "Conseil de Perfectionnement des Écoles d'Infirmières"[2] was instituted whose duty was "to study changes and improvements to be made in the curriculum and in all matters concerning training schools' organization and general progress."

This Board has effected very important work since 1922. It had to grant the "equivalences du Diplôme d'etat" (Registration granted to nurses for past service) and the members of the Board had to divide the work among them: 22,000 candidates sent in their applications for registration, each application had to be studied and reports were to be presented to the meetings of the Board. In 1923, the existing schools sent in their applications to obtain "State Recognition." Most of them had, of course, to effect great changes in their methods of training. Five training schools only (not counting the Paris ones) had a two years' course before 1922. All of them had to make a considerable effort towards better training. After five years, France counted fifty-three recognized training schools for hospital nurses, among which about eight or ten had added a third year for public health. There are now eighty recognized training schools.

We may here venture to say that this considerable progress made on entirely new lines was partly due to the repeated rounds of inspection made through France by a nurse who was vice-president of the "State Committee for Improvement in Nursing." The first tour brought her to Nantes where no school existed then; to Bordeaux, to Toulouse

[1] *J. C. N.*, October, 1927, "Hygiene et Service Social en France, 1900-1927."

[2] "State Committee for Improvement in Nursing."

where old-fashioned schools[3] existing in the State Hospitals were based on a one-year course system; and to Dijon where a two years' course had existed but where the school had trained no pupils after the great war. Another tour included Marseilles, Montpellier, Beziers, Nimes, Avignon, all those southern towns being very anxious to start training schools in their municipal hospitals and conform to the new state program. Other tours followed during two whole years at the rate of about a fortnight each month. In 1922, three town-hospital schools were giving a two-year course. In 1925, there were already twenty-three among which more than half were run by religious orders. Figures are sometimes eloquent! In 1924, the state examinations began to take place. The same nurse travelled again in order to preside over several of the juries which were appointed by the Minister of Hygiene. Now, as the *American Journal of Nursing* has already stated,[4] this work of inspection is going on with a regular inspector on a financial basis—as the former one was entirely at her own expense. The work of the new inspector is highly interesting. Nursing training and education have now a good standard all over France, and it may be hoped that it will still be raised year after year along the lines laid down.

## II

### *Progress in Professional Organization*

HERE we must briefly review the kind of organization existing in France before the eventful year 1922.

When the religious nursing orders were sent away from most municipal hospitals of Paris, a class of women who had hitherto worked in the wards under the nuns came into prominence and entered nursing as "surveillantes."[5] They were good women, some of them very devoted to their patients, but they had no social status, little or no education beyond elementary school: in a word they were not "ladies." The situation was more complicated by the fact that there were male nurses also working either in the wards or in the operating rooms, and that these had adhered to the trade-unions' movement. They rapidly persuaded their women colleagues to join the Syndicate, which most of them did. This "would-be" professional organization is still in existence, thereby preventing the Paris hospital nurses from joining other professional organizations bodily. Some of them however have joined the National Association of Trained Nurses which was started in 1923 and is now counting 1,300 members.

The history of its foundation must be related here. The writer has been directly interested from its very beginning in 1911.

In the course of that year, Madame Alphen-Salvador, who was the founder of the well-known rue Amyot School, and the writer, as Directrice of the rue Vercingetorix School, tried to start a National Council of French matrons and training-school superintendents. The Superior of Pasteur's Hospital, Mère Catherine d'Ornellas,[6] was invited to join us and study the proposed statute of a new organization for the advancement of nursing. As there was at the time no State Diploma existing, we thought the first step was to bring together a

[3] Excepting the Florence Nightingale School at Bordeaux, which was a private one.
[4] November, 1925.
[5] Sisters.
[6] She was succeeded by Mlle. de Jonnis well known in this country.—Ed.

Board of Councillors chosen among the prominent French founders of hospitals and nursing-schools, in order to promote the best methods of education in nursing. A few meetings were attended but no final decision was taken at the time.

Then came the Great War which absorbed every activity and prevented further progress. But, with the war, such a stimulus was given to nursing in France that when the first Ministry of Health was created, in 1920, its first step was to decide about Registration for Nurses.

In consequence of this new state of things, the writer was able to prepare the ground for a National Association of Trained Nurses. The first meeting took place in October, 1923, and although Madame Alphen-Salvador was no more, the same spirit of union presided over the whole proceedings. The writer was elected as President, Mère Catherine d'Ornellas[7] as vice-president, Mlle Lefèbvre as treasurer. All the prominent training schools of the country were represented by their matrons or superintendents and the rules and regulations laid down. The Red Cross Associations had one delegate.

The aims of the Association were:

(1) to raise the standard of nursing in all branches of work;

(2) to study all matters relating to public health and to stimulate professional effort in this direction;

(3) to promote the interest of hospital and public health nurses and help them towards mutual aid and old-age pension funds (superannuating scheme);

(4) to encourage sympathy and intercourse with nurses of other countries and to represent French nurses in the International Councils and Congresses.

It was decided that registered nurses would enter the Association through individual membership, and should be required to prove at least three years' service with State-Diploma, in order to be entitled to a vote.

The news was spread through the journal which had been started in April, 1923, under the title *L'Infirmière Française*. It was a monthly magazine, published under the united direction of Professor Calmette for the technical part and the president of the Association for what was called "Bulletin Professionnel." This journal is now counting 4,000 subscribers and has been put from January 1, 1929, under the sole responsibility of the National Association.[8]

One year passed, during which three hundred members joined and then came the Helsingfors Congress of the International Council of Nurses. On this occasion, the French National Association was affiliated as a member of I. C. N. and it was a moving experience, indeed, when on the platform of the big Hall in Helsingfors, France was solemnly introduced to the nursing representatives of thirty-three different countries and the "Marseillaise" was sung by the beautiful Finnish choirs. The representative of Canada had been chosen to give the formal receiving speech. . . .

After this official consecration of the French Association of Trained Nurses, new prominent members brought in their subscriptions among which we were glad to count Dr. Anna Hamilton, founder of the Florence Nightingale School in Bordeaux. Mlle Mignot, Sous-Directrice of the training-school, had already been elected on the Board.

After five years, our Association is counting 1,200 members. It held, in June, 1928, its first National Congress in Strasbourg. A number of

[7] Of the Religious Order of St. Joseph de Cluny.

[8] Editor, Mlle Chaptal; Publisher, Poinat Library, 21, rue Cassette, Paris (6e).

religious sisters have joined as hospital registered nurses, and several of them took part in the Strasbourg meetings. Moreover, amongst the members of Conseil de Perfectionnement des Ecoles d'Infirmières, there is a religious sister, Matron of the Municipal Hospital and Training School at Nantes.

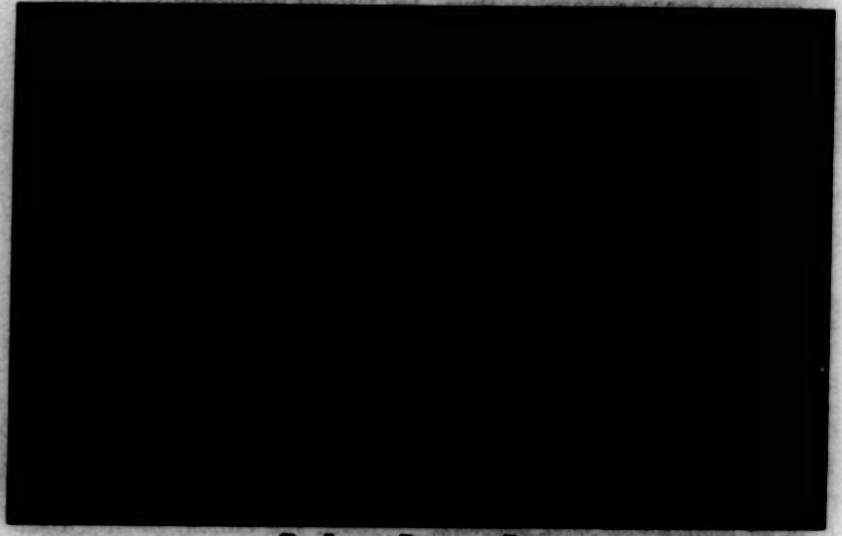
Religious nursing orders have conformed to the rules laid down by the Ministry of Health. Their nuns get the same training as lay nurses and several important training-schools take both religious and lay pupils together. Tradition here has not lost its rights with them; it has kept its best side, perfect devotion to their patients and faithful loyalty to their hospitals. The nuns have worked hard to get what was lacking in their previous training: better technical knowledge, washable garments when on duty, etc. . . . One cannot help feeling that there is something new under the sun, after all. . . .

# Jacob E. Wile Memorial Nurses' Residence

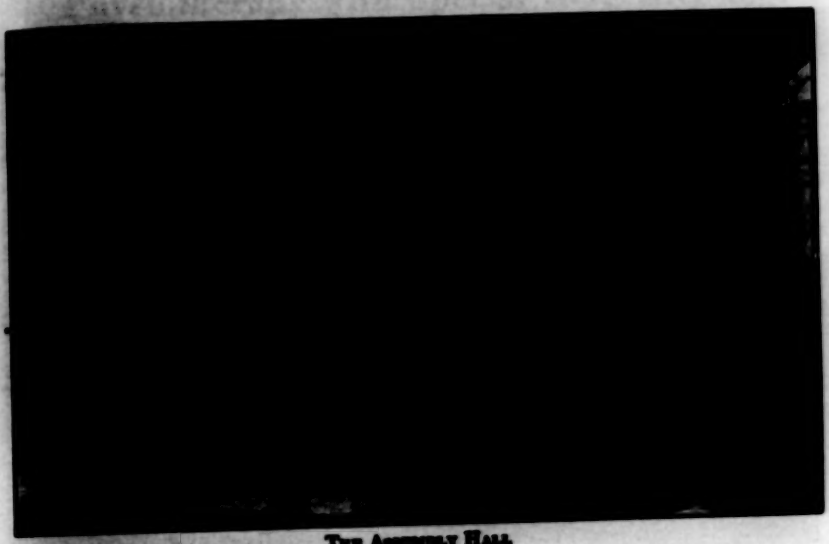
FRANCES S. MACMILLAN, R.N.

THE dedication of the Jacob E. Wile Memorial Nurses' Residence, connected with the Methodist Episcopal Hospital, Indianapolis, Indiana, took place November, 1928. This building cost approximately $600,000 and was made possible largely through the generosity of Mr. John A. Wile, in memory of his father whose name it bears.

This building will comfortably accommodate 300 nurses and is constructed as nearly as possible of non-combustible materials, using a steel frame and reinforced concrete slabs. All of the finished floors are of tile or



THE LARGE RECEPTION ROOM



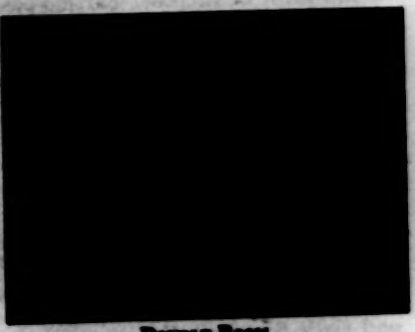
THE ASSEMBLY HALL

SEWING ROOM

terraces, all of the interior trim and frames are of metal, and all exterior windows have metal casement. There are four enclosed stairways and two passenger elevators.

The design is in simple style, with brick as the general material for the exterior, trimmed with Bedford stone. There is an open court to the rear, of such dimensions as to flood all rooms with sunshine during a part of each day.

The ground floor consists of a lecture room, a diet laboratory, chemical laboratory, dark rooms, equipment and supply rooms, in connection with the scholastic portions of the building, linen supply rooms, sewing room, trunk storage, and a small dining hall and kitchen.



DINING ROOM

The south wing of the first floor houses the main auditorium with a seating capacity of approximately five hundred, exclusive of the stage. This room is designed so as to be

The Sun Parlor

accessible from the street level and can be used without interfering in any way with the routine of the remainder of the building. The auditorium is equipped with stage, dressing rooms, and the necessary equipment in the form of fireproof moving-picture booth, etc., to accommodate the modern type of entertainment.

In addition to the auditorium, the first floor also contains the library, general offices, two small reception rooms, two large reception rooms, classrooms, demonstration laboratories, the living suite of the Superintendent of Nurses, instructors' office, storage space, and equipment rooms for use in connection with the classrooms.

On the second, third, fourth, fifth, and sixth floors are the nurses' bedrooms, each of which contains a lavatory, a clothes closet, and a built-in dressing table. In the double rooms, of which there are a few, there are two windows and each student has her own desk, chairs, clothes closet, dresser, and mirror. Each of the rooms is provided with a return-call system, so as to communicate with the nurses direct from the office. Ample and roomy toilet facilities and bathrooms are provided at each end of the building and the supervisors' rooms are equipped with private bath. Each floor contains a large recreation room; a small infirmary is located in the south wing.

The seventh floor is devoted to recreational and social purposes. It contains two open porches and a sunroom, approximately 25 by 80 feet, equipped with a large fireplace and the necessary refrigeration, stove, etc., to allow buffet suppers to be served.

# Physiotherapy with Special Reference to Diathermy[1]

GRADY ACKER, R.N.

PHYSIOTHERAPY, a word coined by the Army, is the treatment of disease by the application of massage, heat, light, water and certain forms of electrical current. Prior to the World War, electrotherapy in general was very much discredited in America, due to the fact that the different modalities of this therapeutic agency were used by semi-quacks in the profession to extort money from credulous victims. In Europe the situation was quite different; electrotherapy remained in the hands of highly trained experts, most of whom were at the same time roentgenologists. The American physicians who accompanied the American Army to France had the opportunity to observe and appreciate the value of sound electrotherapy, and the lessons gleaned from the World War have given decided impetus to the higher development of physiotherapy in this country. Today, the American Medical Association is leading the proper advancement of physiotherapy through its Council on Physical Therapy and we find physiotherapy on an irresistible march of progress for the benefit of the medical profession of mankind.

Diathermy, the latest development, and unquestionably the most useful of physiotherapeutic agents, is used in two distinct forms: medical or constructive diathermy and surgical or destructive diathermy. This paper will be limited to medical diathermy, as it is the form which the nurse is most likely to be interested in.

[1]Read before the Louisiana League of Nursing Education, Shreveport, April 19, 1920.

Medical diathermy is nothing more than an improved method of employing heat as a therapeutic agent. Heat is one of the oldest factors used in the relief of human suffering. In reviewing the methods of its application, one is reminded of the hot stones, bricks and poultices, the most primitive, and later on the hot water bottle and electric pad. Heat obtained from these methods is superficial and thereby limited in its healing properties; while with diathermy we are able to administer heat within the deep tissues, in fact it has been described by some authors as an "internal poultice."

Diathermic heat is generated within the tissues themselves by the resistance which the tissues offer to the electrical current passed through them. It is well known that if the (60 cycle) alternating current, such as is commonly used for lighting purposes, is passed through the body, painful sensations—sensations termed slight electrical "shocks"—are felt. This is because the frequency of the alternation is low, that is, the current is relatively slow in reversion of polarity, and with each alternation violent muscular contractions are experienced. The current produced by a diathermy machine is called a high frequency current which has a quick reversion of polarity, running into many thousands of alternations per second, and the only sensation felt by the subject through whom such a current is passed, is heat. The heat is obtained when two poles of the high frequency current are applied to any part of the body; the current passing from one pole to the other by the shortest route. Diathermic heat is not produced in the

electrodes which remain quite cool, but in the tissues themselves through which the current is passed. By changing the relative size and position to the opposing electrodes, the heat may be diffused through any part of the body, concentrated at will around any desired point.

Diathermy is of value wherever heat is indicated. The actions of diathermy are essentially the same as those of heat in general. In giving the effects of diathermy, Dr. P. G. Bowman describes the effects as:

> First, the sensory nerves, which, in turn, produce a lessening or cessation of pain that may be present; Second, the motor nerves or, as the case may be, the muscles. The heat acts on the smooth and striated muscles, causing a decrease in the tonus. It is, therefore, a suitable means to overcome cramps; Third, the blood vessels. The heat produces an active hyperemia and thereby accelerates blood circulation. This increase in the circulation produces, in turn, a series of other actions of which, as the most important, may be mentioned an increase in the metabolism and an improved absorption.

Among the conditions most amenable to diathermy are sprained joints, traumatic conditions of muscles, neuritis, arthritis, neuralgia, lumbago, sciatica, bronchitis, pleurisy and pneumonia. The quieting anodyne action of diathermy is of special value in all of these conditions. It is a common occurrence for patients to fall asleep during the course of a treatment.

Of course diathermy, like any therapeutic agent, may be used and abused. It should always be given under medical supervision. In fact all the physical therapy departments in our hospitals should be under the supervision of a physician who has taken special work along this line, but the ideal assistant for such a director is the nurse who has also made a study of this work. Special courses in physical therapy technic are being given in a number of the larger hospitals, and when we review the progress of physical therapy in the last ten years, one wonders with amazement what the future holds for this science and the nurse ever eager to serve and to progress should, it seems, be attracted by this new field of work.

### *The Nightingale Pledge*

REPRINTS, in color, of the beautiful illuminated Nightingale Pledge, our frontispiece for May, are for sale at the *Journal* office, 370 Seventh Avenue, New York. The price is 25 cents each.

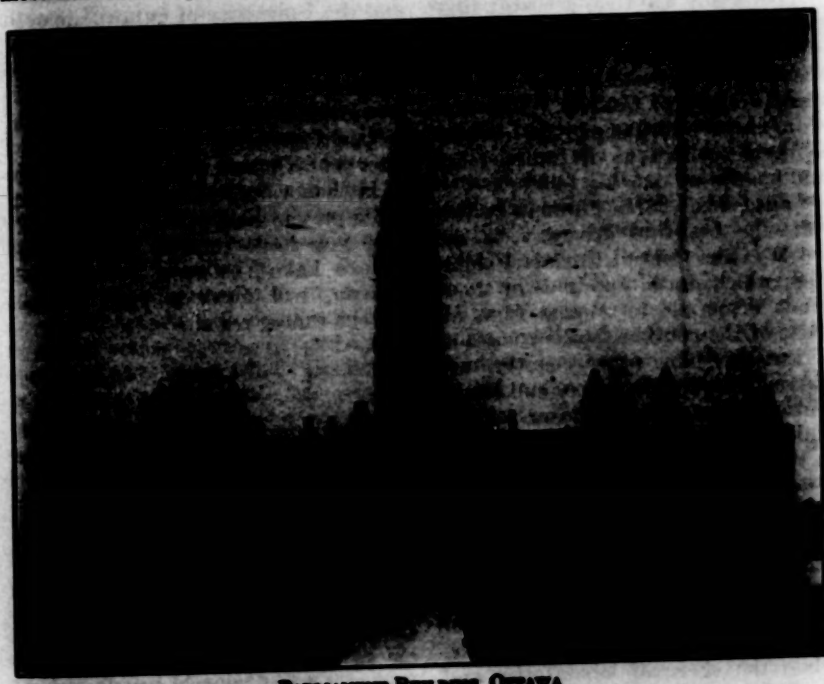
### *"Peter Pan" is Now a Gold Mine for a Children's Hospital*

WHAT child hasn't seen Peter Pan either on the stage or in "the movies"? And now every time any child, young or old, pays for the delight of seeing that whimsical play of Sir James Barrie's, some of the money will go to help little sick children in London to get well again. For that beloved author has given over unconditionally to the Hospital for Sick Children in Great Ormond Street, all his rights to royalties from Peter Pan, a gift which it is estimated will add something like $10,000 a year to the hospital's income. This generous action has already borne fruit, for "the first pirate" has anonymously given a pound note (nearly $5) to the hospital, hoping that others might follow his example.—Children's Bureau, United States Department of Labor, Washington, D. C.

# Glimpses of Ottawa

LEO COX

OTTAWA, capital of Canada, is preparing to welcome the hundreds of nurses who are expected to attend the convention of the Nurses' Association, to be held in Montreal in July, 1929, for no glimpse of Canada can be said to be adequate without a visit to what some call the most beautiful city in the Dominion.



PARLIAMENT BUILDING, OTTAWA

Ottawa is only a short run from Montreal, about three hours by train, reached either by the Canadian Pacific or Canadian National Railway, while the motor drive is one which cannot be easily forgotten.

If your stay in Ottawa is likely to be a short one, you can do no better than obtain a guide, either from the automobile club or from any travel agency in the city.

The first place to which your guide will take you, undoubtedly, will be the Dominion Parliament Buildings, a magnificent block of three separate buildings in the best Gothic tradition, in the center of which rises the famous Victory Tower, work on which officially reached conclusion in 1927. On July 1, last year, the dedication of the Victory Tower to the country was one of the remarkable features in the ceremonies attendant upon the sixtieth anniversary of the Confederation of Canada.

The Victory Tower contains a now famous carillon of fifty-three bells, cast

at Croydon, near London, England, which have been played by various internationally known carilloneurs. Each summer the carillon concert is one of the attractions of a visit to Ottawa.

On the other side of the buildings are beautiful grounds which drop sheer down into the broad, swift Ottawa River. From here a magnificent view is obtained up and down the river and across to the thriving town of Hull, in the Province of Quebec.

Your guide will then probably take you to the Victoria Memorial Museum, in which is located temporarily the collection of paintings of the National Gallery of Canada. This museum also contains one of the most remarkable collections of Indian relics and handiwork existing today.

Lansdowne Park, through which runs the beautiful driveway, is the locale of the Central Canada Exhibition, which draws hundreds of thousands of people in August from all parts of the continent. Few cities in Canada, or any other country, are blessed with so many trees and boulevarded streets as is Ottawa. Parks and gardens are its great glory.

Your guide will then undoubtedly take you to the Experimental Farm, leaving the Ottawa-Prescott provincial highway. On this beautiful and orderly farm you would be able to examine the immense flower beds, fascinating green houses, orchards of fruit trees, bees, horses, chickens; while the chemical laboratories and the Dominion Observatory would keep you interested for hours.

Chaudiere Falls is one of the beauty spots of the city. Here you can see the majesty of the Parliament Buildings on the high river bluff. In a street-car ride, or motor drive around Ottawa, you pass the gates of Rideau Hall, the residence of the Governor-General of Canada. The grounds are extensive, although the residence is modest, yet in the best taste. Further on is Rockcliff Park, comprising about 90 acres of as pretty a park country as you could find anywhere in America. The view from the Park over the river is even more beautiful than you have yet seen.

Your guide will probably also show you the residence of the Premier of Canada, the Sacred Heart Church, and the University of Ottawa, as well as other points such as the Royal Mint, Nepean Point Park, and the entrance to the Rideau Canal. The first locks of this canal were built by a certain Colonel By a century ago; in later years Ottawa was named Bytown in his honor, and afterwards changed to its present name.

If you have time, a trip to the Rideau Lakes, between Toronto and Ottawa, will repay a visit to this famous fishing region.

### *Queensland's Maternal Welfare Problem*

THE Government of Queensland, Australia, has already opened sixty-four maternity hospitals, and eleven more are in process of construction. The hospitals were first provided for the sparsely settled "bush," but are now being built also in more populous centers. A rural nursing program is being developed, and prenatal clinics are being associated with the maternity hospitals in an endeavor to reduce the rate of maternal mortality, which has not appreciably declined in Queensland during the last twenty years. The infant mortality rate of the State, on the other hand, is unusually low. For a recent five-year period it was a little over 50 per 1,000 live births. The lowest rate for any state in the United States birth-registration area, during the same period, was that of Oregon which was over four points higher, but the rate for New Zealand was only 41.—Children's Bureau, Washington.

# Nursing in Siam

ALICE FITZGERALD, R.N.

SIAM is still quite off the beaten tourist track and there are only about 1,200 foreigners of all nationalities in the whole country, exclusive of the Chinese, of whom there are many times 10,000. It was, therefore, a distinctly different world in which the two nurses invited to reconstruct the nursing service at the Siriraj Hospital in Bangkok found themselves.

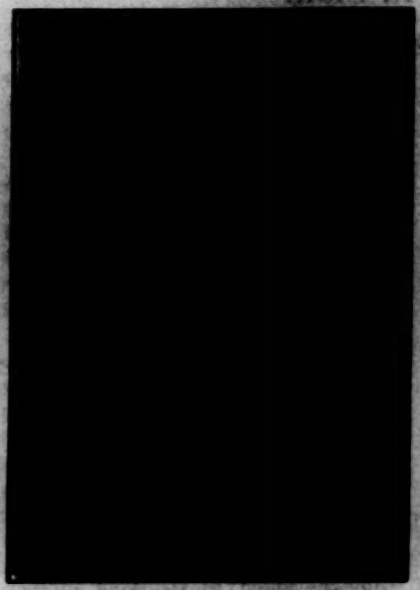
Siam is situated between Burma, Indo-China, and the Federated Malay States, and its capital, Bangkok, is built on the shores of the largest river of the country. It covers an area of about 200,000 square miles and has a population of about 10,000,000 people. Siam is very rich in water-ways and most of the population has settled along or near the shores of the rivers or canals, as their daily food and their means of transportation depend upon facilities for fishing and proximity to anything which floats. The rest of the population lives on junks, and drifts with the tide or moves, according to the needs of the "seasonal cargo."

Many of the homes are built over the water on piles, and the question of drainage, sanitation and disposal of waste is immensely simplified, as everything not wanted goes into the water. This habit of disposing of everything out of a door or window is deep-rooted, and many of the nurses had great trouble to adapt themselves to the rules of the home which called for other disposal of waste than that provided by windows or doors.

The clothing of the Siamese is sanitary, modest and attractive. It consists of a straight strip of cloth or silk, about three yards long and a little over one yard wide, which is known under two names, according to the way in which it is worn. The "panung" is wrapped around the waist and the two ends which are brought to the front are twisted, carried back between the legs, and fastened at the waist behind, giving the effect of sensibly large and comfortable divided skirts which just cover the knees. The "sarong" is also wrapped around the waist but is left hanging straight down. Men and women dress alike from the waist down and choose lovely, bright-colored panungs and sarongs. From the waist up, the men wear European clothes and the women a modification of the well-known blouse which follows the variations of fashion and changes from the short to the long jumper style, as Paris dictates.

The religion of the country is Buddhism and the numerous temples scattered throughout the cities and countryside are very beautiful with their unusual and fascinating grouping of delicately outlined buildings of all sizes and shapes in lovely old, shady gardens. What could be more beautiful than a temple under a bright blue sky with the dazzling sun shining on the mosaics of many colors made with pieces of glass, china or pottery which are seen on so many of the buildings? Then to supplement this orgy of coloring, are found the priests in their bright yellow robes, the natives in their vivid panungs or sarongs and all conspire to surprise and to hold, but never to shock, the eye.

The Buddhists are a very contented people and live up to a philosophy which makes for peace, restraint and poise. The people show a marked absence of the unpleasant reactions to anger, to fright, to displeasure, so



THE AUTHOR AND ONE OF HER PETS

common in some countries, and in a nurse this is indeed a quality which is very reassuring in the face of an emergency or death. It was most unusual to hear a child cry and in the hospital even patients in severe pain rarely moaned aloud. This was most marked in the obstetrical ward where even the long and hard deliveries were no cause for breaking the usual silence.

Siam is an absolute monarchy and rank plays an important part in all intercourse, be it social, business or professional; it governs relationships and friendships and creeps into the smallest details of the daily life of the country. The education of the girls is making marked progress, and within the last years, studies comparable to the last two years of high school in the United States, have been introduced into the most important girls' schools of the country. The number of students who avail themselves of these advanced studies is increasing from year to year and this is due, at least in part, to the fact that the schools of nursing are raising their requirements for admission and that the university is opening its doors to the young women who wish to study medicine or law.

For the general public in Siam to recognize the fact that women are entitled to take up professional work, that some of the public is furthermore willing to have its daughters enter the professional schools, is already an important step in the right direction. If one bears in mind that it is necessary to "make haste slowly" in the East, one can see signs of a bright future for nursing in the Orient.

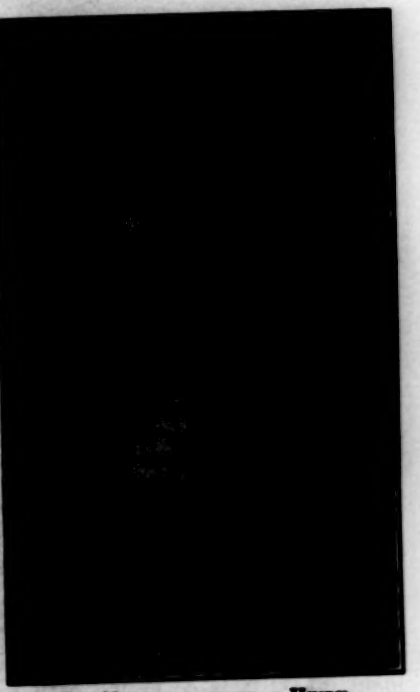
Nursing in Siam has had three patrons, the Red Cross of Siam which was the pioneer and did much to establish early standards and to enforce them by awarding the only available and recognized diploma of nursing until the other schools were in a position to award their own; the Government, which directs the Siriraj Training School for Nurses; and the Presbyterian Mission, which has a very excellent hospital and a young and already efficient school for nurses at Chiengmai in the northern part of Siam. There is room for these and for more schools and as soon as the Nurses' Association of Siam is strong enough to secure protective legislation for the profession, with good registration laws for both schools and graduates, the establishment of new hospitals and schools should be welcomed by all.

The development of nursing in the Red Cross School has been entirely under Siamese control but the chief nurse is a graduate of an American school and has given devoted service to the cause with the loyal support and backing of the authorities. The Red

Cross Hospital, known as Chulalongkorn Hospital, has large modern buildings, connected by covered walks, situated in extensive and beautifully kept grounds. Though the Red Cross finances the hospital and the school for nurses, the Army administers both. It speaks well for the staff for both hospital and school that the hard and fast rules of the Army have not submerged the nursing authority. There is also a school for male nurses whose candidates are selected from among the recruits for military service, who carry dual responsibilities with the balance of weight in favor of the army drills and parades which make heavy calls upon their time and often at the cost of the nursing training.

The great prestige enjoyed by the Red Cross of Siam enables the school to enroll a high class of applicants and to secure a number of very desirable young women. Some of them have been sent to foreign countries for postgraduate training in public health nursing in which the Red Cross is doing good pioneering work.

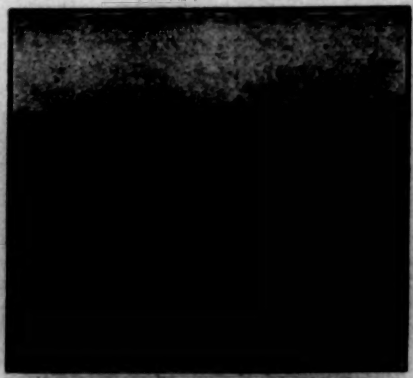
The nursing school of the Mission Hospital in Chiengmai is directed by foreign nurses and the permanency of this arrangement ensures a stable foundation upon which to build. The standards of this school have been held so high that very few applicants can meet them and fewer still have been able to finish the course. Whether it is wisest to start with prohibitively high requirements or to start with more modest ones and strive to raise them, is a question which each administration must settle for itself. The McCormick Hospital, with which the school is connected, is housed in fine new buildings, very sensibly modern, and has a remarkably active service in the different branches. The institution has the patronage of royalty and the affection of the people.



Our Nightwatchman—a Hindu

Much of this is due to its director, a most indefatigable worker whose personality radiates energy and stimulates ambition in all the members of his staff and his corps of helpers. He is a firm believer in good nursing and will not be satisfied until he has the best for all his patients.

As in some other countries of the East, the training of midwives has preceded that of nurses, and at the Siriraj School in Bangkok the nursing course has been grafted upon the old and well-established school for midwives which was founded and endowed by a former Queen of Siam. This sequence in events has been interpreted by the students, in the past, as meaning that the years of general training were merely a necessary introduction to the all important



A sampan rowed from the bank in Siamese style. The man is wearing a sarong, the Siamese equivalent for trousers and, as customary, a European shirt.

training in midwifery and of no special value in themselves.

In spite of this rather temporary handicap of being the young and unknown sister of an older one of royal parentage, the School of Nursing of Siriraj Hospital is very fortunate in many ways; it is connected with a hospital which serves the University Medical School and which for this reason has unusual teaching and clinical facilities, and for the time being, has a large staff of foreign professors and clinicians familiar with modern nursing. It is one of the activities of the Ministry of Public Instruction (or education) which is in a position to assist in guiding schoolgirls towards the profession through suitable publicity in the schools, and in time to introduce into the advanced grades those studies which might be termed pre-nursing and which could be made elective.

The hospital has a rather interesting history which accounts for the peculiar variety of odd buildings making up the institution and the apparent lack of order in which they stand. The buildings were originally erected for the cremation of Prince Siriraj, and in those days a whole village or settlement was put up to house the relatives and their followers who assembled for the ceremony.

The original crematorium itself was used for years as the operating room and was quite practical and certainly unique of its kind, but after serving in this capacity and then as a central linen room and sewing room, the old landmark has disappeared and its epitaph might read "useful to the last." When the plans for the new hospital are fully carried out, the institution will be second to none in Bangkok. Curious to say, this hospital can only be reached by footpaths or by boat, as there are no roads on that side of the river, consequently most of the patients are laboriously brought to Siriraj by sampan and anyone intimate with this mode of transportation will readily understand what this means in terms of delay, inconvenience and discomfort to the patients. This is particularly true of very ill patients on stretchers which are most difficult to lift in and out of the low boats.

For about eight years before the arrival of the two nurses engaged by the Government to assist in the reorganization of the school, it had been directed by a most capable Siamese nurse who had received her training in Manila, and to her years of effort and struggle was due the fact that the school existed and that the patients in the hospital were receiving nursing care. This chief nurse had worked practically lone-handed. The situation was made even more difficult by placing over the professional head a lay woman with no knowledge whatever of hospital or nursing work but whose authority was absolute.

It had been the custom to divide the nurses into three groups, one for

each of the three services in the hospital, and the chief of each service had absolute control of his group concerning hours off and on duty, vacations, days off, discipline, sickness, etc., for one-third part of the whole period of training. There was no attempt to see the hospital as a whole, and a busy ward had no claim for help from one of another service which might have few patients. Nurses were known to refuse to go to another ward because "the doctor had said that they were not to be moved except by his order." In other words, three hospitals of the "one-man type" were being run in the institution. The complete authority of the doctors was also seen in the plans for the instruction of the nurses, where each specialist claimed a maximum of hours without any consideration for the other subjects and with no regard for the total number of hours. For instance, 400 hours were given to anatomy and physiology and it required a drastic operation, which should have been performed under an anesthetic as it seemed so painful, to remove some of the surplus hours from the instructor in these two subjects.

Every graduate and undergraduate nurse in the hospital was granted twenty-four hours off duty each week, and these days (and nights) off were all given on Saturdays and Sundays, so that for two days a week only one-half of the staff was on duty and this quite regardless of conditions in the hospital. Special leaves, vacations, etc., were granted for the asking and the nurses had but little sense of responsibility towards the patient or the hospital, and were ignorant of the very elements of professional ethics.

Perhaps one of the most helpful moves towards assisting the visiting nurses in their undertaking was the

A Junk

transfer of the nurses to the new home provided for them by a high-ranking prince, a friend of the profession, outside of the hospital compound, thus giving the school, for the first time, the feeling and the appearance of being a unit of some importance. Step by step necessary changes were brought about. The lay direction was replaced by all-professional authority under which the nursing service was coördinated. Efforts were made to provide supervision for all the hours of the day and night and special attention was given to rules governing the nurses' residence. Days off duty were cut down to two a month, and extra leaves were discouraged, but even so, the long list of religious and official ceremonies which had to be attended in addition to numerous family celebrations, often cut down the nursing staff to an inefficient minimum.

These and many other changes were made gradually and with the most loyal coöperation of the Siamese heads in the school. To them, the new régime under the visiting nurses must have seemed like a series of earthquakes or upheavals, with much destruction of the old and much upbuilding for the new, but though no one can actually like earthquakes, the nurses bore up wonderfully well under the ordeal and it is because of their loyal help and friendly willingness

that it was possible to make any progress. The many hospital housekeeping problems which so greatly affect the nursing service were taken up in turn, and the linen supply, the laundry methods, the ward equipment, etc., were systematized in order to meet the needs of modern bedside care.

Today the nursing course is of three years' duration, for general training, and an additional obligatory six months for midwifery. The requirements for admission, which it is hoped to be able to enforce and to gradually raise, call for a completed sixth Matayome or about two years of high school. The curriculum has been entirely revised to meet accepted standards, two nurses, one the chief nurse, were sent to Manila for post-graduate work, graduate head nurses and graduate assistants were assigned to all wards and departments, a Matron was placed in charge of the Home and an assistant to the chief nurse and three supervisors were appointed. All the graduates, with the exception of the chief nurse and her assistant who were trained in Manila, are Siriraj nurses.

The system of three shifts of eight hours each has been in force at Siriraj Hospital for many years; besides being very extravagant in personnel, and inelastic in practice, it is rather doubtful if the long unbroken hours are not too exhausting in the tropics and whether better service would not be rendered through the system of broken hours. The nurses who went on duty from 7 a.m. to 3 p.m. were working during all the most trying hours of the day and it was most noticeable that however fresh in appearance and enthusiastic in manner the nurses may have been at 7 a.m., they were apt to become dull and listless towards noon, and no one could blame them for showing the effect of the heat.

The home life of the Siamese women is so protected that it was necessary to enforce very strict rules regarding visitors and permits to go out. All outgoing and incoming mail was read by the Matron and no "convent rules" could have been more rigorous than those at Siriraj. Time rights most things, and undoubtedly education, domestic problems, professional aspirations, will modify the strict supervisory discipline of the young Siamese women with benefit to them, in more self-reliance and better means of "auto-protection," and to the profession in better preparing young women to face the problems of life and assuming the responsibility of leadership.

Nursing cannot be successfully developed and placed on a sound basis unless the public at large and the authorities concerned, particularly the medical profession, are taken into the confidence of its leaders and taught to understand its aims and aspirations, as well as its methods. The fact that medical students are now being trained side by side with the nurses in the wards of Siriraj Hospital is a hopeful sign for the future, as we must look to these doctors "in the making today" as the friends and colleagues of the nurses of tomorrow in Siam. This should not give the impression that the nurses are friendless for they are not, and some of the Siamese doctors in the hospital now are firm believers in modern nursing and have assisted in making what progress has been made possible. For instance, one surgeon was so incensed at the rudeness of a patient to a Siamese nurse that he discharged the patient and others who also needed the lesson. Such a public demonstration of respect and friendliness goes a long way towards improving the

masses and proves to the nurses that they are not without champions!

The Siamese young women are attractive, their manners gentle, their voices quiet, their dispositions cheerful and even and, once their confidence has been gained, they are easily influenced and led. They do not mature early and seem mere children at the age of seventeen or eighteen; probably this is due to the isolated and protected life which they live in their own homes. Many of them, however, develop rapidly in the school and readily assume responsibility. They are not as fond of studying as are the Filipino girls, but they take kindly to manual training which in many cases has been entirely neglected in early life, for few have been taught to use needle and thread.

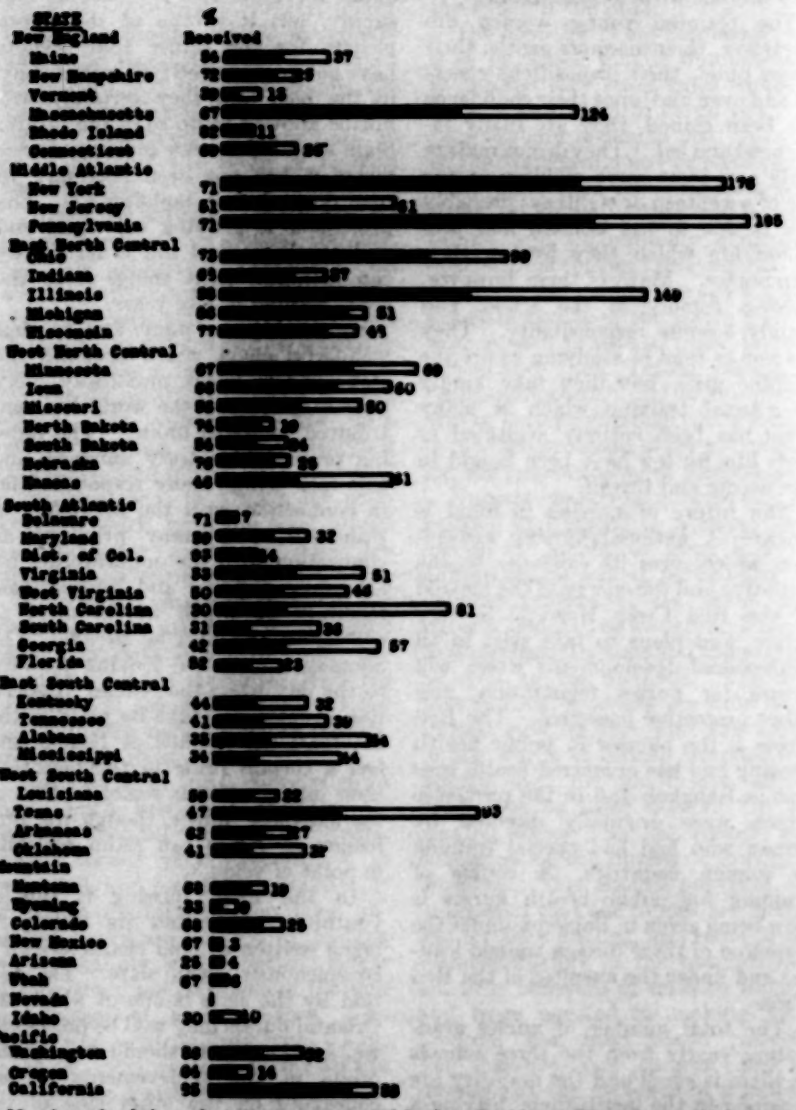
The future of nursing in Siam is bright. A national nursing association which owes its existence to the initiative and the energy of the matron of the Red Cross Hospital is very active, and plans to take part in all professional developments which will secure for nurses registration, and other protective measures. The Red Cross is the pioneer in public health nursing and has organized health centers in Bangkok and in the provinces which were originally directed by nurses who had had special training in foreign countries. A course of training for public health nurses is now being given in Bangkok under the direction of these foreign trained leaders and under the auspices of the Red Cross.

The total number of nurses graduating yearly from the three schools in Siam is small and the majority are retained in the institutions, leaving a very limited number to go into public health or into midwifery. The demand for graduates far exceeds the supply, but it is one of the safest pledges for the future that schools have not been started indiscriminately in the past and they certainly will not be allowed to do so in the future. Siam is one of the few lucky countries where it has not been necessary to tear down before building up. The profession is growing on virgin soil and as all tropical soil is fertile, we can look for great things from the seeds planted in late years.

Siam adds one more link to that wonderful chain which encircles the globe and to which practically every known country of the world has contributed "nursing links." The nursing profession is truly universal and this fact brings many responsibilities in connection with the upholding of standards, and many privileges in connection with the opportunities for attending regional and international meetings at which nurses meet as colleagues and part as friends. The Siamese nurses are looking forward to the day when the Nurses' Association of Siam will take its place in the International Council of Nurses and feel a certain pride in the fact that their organization is senior to that of the Japanese nurses, though the profession in Japan can claim seniority in point of years.

In the East, nursing is full of youthful energy and its history is being written in bold characters on a conspicuously clean slate. The tale told by the slate is one of which the Oriental nurses may well be proud and we, of the West, should be equally proud of the achievements of our colleagues on the other side of the world.

# Grading Returns




Nursing schools in each state are represented by length of bar. Those from which Grading reports have been received by June 10 are shown in black. Reports are still coming in.

# The Pension Fund of the Alumnae Association

*Mt. Sinai Hospital School of Nursing, New York City*

JENNIE GREENTHAL, R.N.

THE question of provision for persons in all walks of life, whose earning capacity has diminished because of age or other disability, is receiving increased attention as time goes on, but a satisfactory answer is still being sought. For nurses, in particular, the solution is a difficult one.

About twenty years ago the Alumnae Association of the Mt. Sinai Hospital School of Nursing was confronted with this problem. Many of its members, through no fault of their own, had not been able to make adequate provision for the contingencies arising in later life, and it seemed imperative that some plan be devised which would be of assistance to them. A survey of the situation in an attempt to ascertain what had already been done along the lines indicated was rather discouraging. Apparently, only pension funds which were heavily endowed, as the Carnegie Fund, or which received large contributions from municipal or federal governments, were functioning with any degree of efficiency. The outlook for such endowment or subsidies for nurses in general was not promising, and no existing plan could be discovered which was applicable to our needs. We therefore decided to attempt to work out a scheme of our own.

The good offices of the Board of Directors of the Hospital were enlisted, and the subject was discussed with them from all angles. The need for action of some sort could not be gainsaid; a difference of opinion existed, however, as to whether the attempt should be made to develop a plan along the lines of a pension fund, specifying that any member eligible under the by-laws could apply and receive the pension as a routine procedure, or whether the need could be met more satisfactorily by a so-called emergency fund, to be given at the discretion of the Pension Fund Committee, upon proof of need. The Pension Fund plan was favored by the majority, who felt that it could be administered with less friction and without loss of self-respect to the recipient.

The kind of assistance agreed upon, the next step was to put through an amendment to the constitution of our Alumnae Association, authorizing the establishment, maintenance and distribution of a pension fund. This was finally accomplished after some difficulty, owing to the stringent laws governing such undertakings in the State of New York. The by-laws were also amended to the effect that only members of the Alumnae Association were eligible for Pension Fund membership; the dues to be $10 per annum in addition to Alumnae dues; no member to be eligible for a pension until she had paid $200 into the treasury, was fifty-five years of age, had been nursing for twenty years, or had supported herself by other occupation for the required period after nursing for five years; if incapacitated before these regulations were complied with, the pension could be awarded upon recommendation of an examining physician and a favorable report of the Pension Fund Committee.

A committee of six members of the Pension Fund was named from which a chairman and treasurer were to be selected, to manage all Pension Fund affairs; the finances were to be kept

entirely separate from those of the Alumnae Association proper; a Finance Committee of three members of the Board of Directors of the Hospital advised upon financial matters, investments, etc. No pensions were to be paid until at least $60,000 were in the treasury; the income, only, of the Fund was to be divided, *pro rata*, among the applicants.

The important question of raising funds was then before us. The Directors of the Hospital gave generously of their time and money; the nurses made personal contributions and interested their friends and patients; but it was seven years before our goal of $60,000 was reached and the Fund could begin to function.

It was an interesting experiment; we had no precedent to follow and were inclined to be cautious. The amount paid was small, but it was much appreciated, for the need was great. As time went on it was found that our income was not sufficient to allow such liberal age and service provisions (fifty-five years of age and twenty years of service) and the by-laws were amended to sixty years of age and thirty years of service, except in the special cases of disability already referred to.

In the meantime, the object of the Fund and the growing public interest in matters of this kind have been instrumental in increasing our Fund to $136,000, and enabled us in 1923 to allot to each of the fifty members who applied and who were eligible under the by-laws, the sum of $165 each, during the year.

So far as we know, ours is the first pension fund for nurses to be established in this country. Although far from perfect, it is functioning smoothly and satisfactorily within the limits engendered by lack of sufficient funds. The amount paid, while not munificent, does help to provide comforts not otherwise attainable, and in a number of other ways makes the sunset of life a little happier for many women who have given the best that was in them to the service of others.

Our results, while gratifying and satisfactory up to a certain point, must be considered as a temporary adjustment, made possible only by the generosity and interest shown by the public in general, and by the Board of Directors of our Hospital in particular. The basic solution has not been reached; it would appear that future effort should be directed toward some form of insurance (preferably compulsory), initiated as soon as a nurse graduates and subsidized, in part, by either hospital or nursing organizations, or both if necessary.

### *The Care of the Patient*

DISEASE in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment. The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.—*Francis Weld Peabody, M.D.*

# Nurses' Relief Fund[1]

## *Of the American Nurses' Association*

JANET M. GEISTER, R.N.

THE question of what we are going to do, as a profession, for our nurses who, through illness and accident, need to have financial aid, is one that challenges the thought of every nurse. Eighteen years ago a national Relief Fund was established. It was born out of a great spirit of fellowship and altruism.

### *Original Purpose*

1. The original purpose of the A. N. A. Relief Fund was outlined as follows:

(a) To provide financial aid in time of emergency.

(b) To give relief to members disabled by illness, accident or from losses by flood, fire and other calamities, or funeral expenses.

(c) To establish a loan fund.

2. Any member of an alumnae, city, county and state organization is to be eligible for the benefits of the Fund.

### *Actual Purpose*

IN actual administration, the project has been limited both by practical financial considerations and by the evident needs of the applicants.

The projected loan fund has proved entirely impractical, and financial aid in time of emergency has been given usually in connection with illness where a definite sum has been needed to take the applicant to another climate. Consequently the main purpose of the Fund has come to be that of giving relief to a nurse who is ill and without other funds.

[1] Prepared for consideration at the meeting of the Advisory Council in Atlantic City, June 20-23, 1928.

### *Finances*

ALL money for the Fund has been contributed voluntarily by nurses. There have been no membership dues or fees required by national organizations. A nurse to become a recipient of aid from the Fund need not have been a contributor. In some states, a systematic campaign has resulted in regular, large contributions to the Fund, while in others, the contributions have been more desultory.

Until 1923, there was always a comfortable margin between income and expenditure. The surplus was carefully invested by the Finance Committee. Since 1923, the demands on the Fund have quadrupled and the amount of money invested has decreased in proportion. In 1928, we closed our books with the first deficit in the history of the Fund. In other words, we spent $3,000 more than we had received from contributions and income on investments.

### *Administration*

THE Fund is administered by a national committee of five members. Until 1926, all work was done on a volunteer basis. This involved a prodigious amount of bookkeeping and correspondence. At present, all banking, bookkeeping, correspondence, and other clerical work is carried on at Headquarters. The National Relief Fund Committee, through correspondence, makes all decisions regarding eligibility, amount, duration of relief, etc.

### *Problems*

THE demands on our Fund are far out of proportion to our income. Our assured income—that from

investments—was $5,532.42 in 1928. The majority of other relief funds established to give aid to their members spend, for relief, only the income that comes from investments. All contributions are treated as principal and are invested to bring greater returns. This has never been the policy of our Relief Fund. We have spent both income from invested funds and current contributions, yearly, investing only what was left over.

If the demands on the Fund, in the next six years, increase in the same proportion as in the last six years, we shall find ourselves in serious financial difficulty. Furthermore, we are making no provision to meet our obligations of the future. The new rulings covering eligibility to the Fund have not decreased the demands. At present we are spending $2,600 a month. To do this on a sound financial basis would require an investment of more than $500,000, as opposed to our present $122,000.

Long range or national administration of relief never has been found practicable by any group. So far as we are able to learn, we are the only organization attempting to do this. It is a fundamental principle, in relief-giving, that the group administering relief must have an intimate and close relationship with those receiving relief. Our experience every day demonstrates the impossibility of obtaining, in a national office or by a national committee, adequate information regarding beneficiaries which is essential in administering this Fund with wisdom. It has been found difficult to tap local resources for their benefit and to aid them in finding other types of work which is so often necessary. The task of getting even the most elementary facts concerning the beneficiaries is almost impossible.

In December, 1928, in order to provide an annual review of active cases, a form was sent out for the purpose of ascertaining the minimum facts concerning each applicant. One hundred and eighty-nine report forms were sent out. In 38 instances, no reply was received. In 151 instances, replies were received, but only 104 contained any recommendations. Many of these recommendations were so meager that they served no purpose. The exceptions to this were in the cases of state chairmen in three states who rendered detailed and carefully-investigated reports. In order to determine whether benefits should be continued or discontinued, during the past few weeks 101 individual letters, 97 form letters and 142 memoranda have been sent out in an attempt to get further information to determine whether the benefits should be continued or discontinued. Some of the replies were so insufficient that further correspondence is necessary, while from others no replies have been received.

A further difficulty is presented in the matter of terminating benefits. On the Fund today are thirteen nurses who have received aid for more than five years. Another group of fifty represents a period of from three to five years. They are ill and cannot return to work. The monthly check is their only regular money income. At present there are but two major reasons for terminating the aid: death, or a return to duty. The Committee is reluctant to dismiss beneficiaries who are still in need, for only in rare instances under our present method can local provision for their care be made.

This seems to be an unavoidable situation. Local chairmen are usually women already heavily occupied with their own professional duties and are usually without stenographic aid.

Neither do they have funds or time to travel to distant points to obtain first-hand information regarding beneficiaries. Furthermore, they cannot spend the time to carry out the plans for social treatment which is a necessary accompaniment to medical treatment and to financial rehabilitation.

The National Committee cannot begin to keep in touch with individual cases scattered all over the country. Headquarters staff cannot possibly do the necessary work, even by correspondence, for already one-fourth of the full time of Headquarters staff is spent on the details of the individual cases. Even with this disproportionate allotment of time from the other work of the organization, we are seriously dissatisfied with the inadequacy of our Relief Fund work.

The simple fact is that the American Nurses' Association is attempting a project which, from an administrative standpoint, is essentially unsound. Experience elsewhere has shown that a salaried staff, devoting full time to the work, is needed. We have not such a staff and cannot afford to have such a one at present.

The suggestion is made that insurance and saving schemes should be emphasized, and a decreasing emphasis placed on relief. These are excellent *preventive* measures that undoubtedly will influence the whole question of economic security for nurses in the coming years. There is a large group of nurses, however, who cannot profit by schemes put into effect today. Their needs must be met at once—they cannot wait for future payments ten, fifteen, twenty years hence. Many are not eligible, through lack of funds to pay premiums or dues, and also because of age or disease.

Another suggestion made is that the fund be used only for emergency relief—that at the end of a given period, payments should be halted. What is an emergency? Every illness, regardless of its duration, is an emergency to an individual who has no money. If an automatic time limit of three or six months is placed on the benefits, are the local associations prepared to take over the responsibility for the individual at the end of that time? If there is no automatic limit to benefits, but each case is terminated when the need is over, an increasing number of cases are carried over a period of years.

Some of the questions before us are:

1. (a) Is it feasible to operate a relief fund on a national basis without the personal contact with the beneficiaries that is considered essential in all modern plans for relief-giving?

(b) Is it right to assume so large a financial responsibility, immediate and future, on so precarious and inadequate an income?

(c) In its enormity, is it a logical project of the American Nurses' Association?

2. If it seems wise to change the distribution of relief-giving, what shall be the plan?

(a) To decentralize?

(b) Will state associations be willing to assume this responsibility in their own states?

# Analyzing Schools of Nursing

## *A Few Facts from the Files of the Ohio Board of Nurse Examiners*

CAROLINE V. McKEE, R.N.

THERE are many methods of studying schools of nursing, but none that portrays what has taken place through the years like graphic pictures. There are curves and columns that can be used to represent cold figures. When thus used figures become interesting, because we can compare the results of the work of the individual schools. It is very gratifying to have a yearly report from the schools in the state filed in the department of nurse registration. However, unless we have some way of representing the yearly progress, we are not in a position always to verify a statement that may seem radical as it relates to a particular school or institution. For instance, when we make the statement that a hospital does not furnish sufficient medical service, we can prove it by referring to Chart No. I. Note that School No. 10 does not have enough medical nursing days per student, and that School No. 8 is low in obstetrical nursing days.

The "aim" designated on this chart parallels the suggested services given in the Curriculum of the National League of Nursing Education and totals 1,080 days. When the total nursing days in any one service falls above the stated quota, graduate service is available. Or when it falls below the "aim," affiliation should make up the deficit.

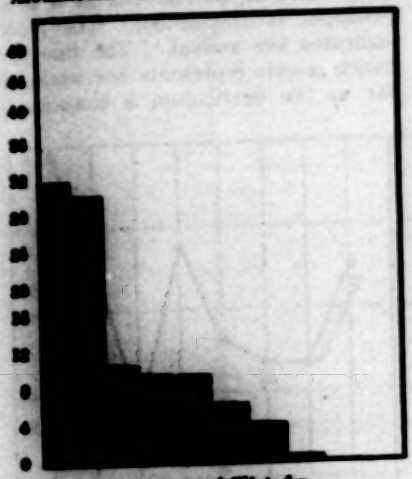
NOTE.—The average days' stay in a hospital of patients in the basic services was submitted by a superintendent who is an authority in hospital administration.

CHART I

| Hospital | No. of Beds | Daily Average | Prel. Term | Med. | Surg. | Obs. | Ped. | O. R. | Disp. | Pub. Health |
|---|---|---|---|---|---|---|---|---|---|---|
| The Aim..... | .... | .... | 120 | 120 | 120 | 90 | 90 | 60 | 60 | 60 |
| 1..... | 225 | 180 | 120 | 146 | 602 | 154 | 90 | 60 | 60 | .. |
| 2..... | 140 | 76 | 120 | 122 | 491 | 82 | 274 | 60 | .. | .. |
| 3..... | 165 | 142 | 120 | 126 | 482 | 82 | 120 | 60 | 21 | 60 |
| 4..... | 90 | 72 | 120 | 120 | 377 | 220 | 90 | 90 | 45 | 60 |
| 5..... | 160 | 70 | 120 | 112 | 371 | 120 | 120 | 120 | 30 | .. |
| 6..... | 110 | 70 | 120 | 178 | 220 | 120 | 120 | 90 | 30 | .. |
| 7..... | 250 | 140 | 120 | 231 | 223 | 112 | 61 | 120 | 30 | 60 |
| 8..... | 100 | 80 | 120 | 120 | 222 | 60 | 142 | 90 | 30 | 30 |
| 9..... | 272 | 120 | 120 | 117 | 222 | 116 | 126 | 60 | 30 | 60 |
| 10..... | 120 | 102 | 120 | 60 | 220 | 97 | 77 | 120 | 21 | .. |
| 11..... | 225 | 120 | 120 | 141 | 221 | 123 | 123 | 65 | 45 | 60 |
| 12..... | 80 | 60 | 120 | 120 | 220 | 72 | 75 | 60 | .. | 60 |

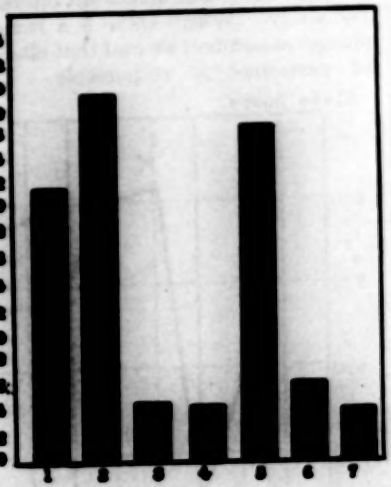
Key-number of patients times average days' stay in hospital divided by number of students shows nursing days

AFFILIATION—49 OF 72 SCHOOLS AFFILIATE



| Schools | Affiliate for |
|---|---|
| 28 | Communicable Disease Nursing |
| 20 | Pediatric Nursing |
| 10 | Public Health Nursing |
| 9 | Medical Nursing |
| 9 | Psychiatric Nursing |
| 6 | Tuberculosis Nursing |
| 6 | Obstetrical Nursing |
| 1 | Private Duty Nursing |

PRINCIPALS AND INSTRUCTORS IN OHIO HAVE THESE CREDENTIALS



| | |
|---|---|
| 1. College Degree | 21.3% |
| 2. College, 1–3 years | 28.7% |
| 3. Normal School | 4.9% |
| 4. High School, plus Summer S. | 4.9% |
| 5. High School Diploma | 27.9% |
| 6. High School, 4–14 units | 7.3% |
| 7. No tangible credits | 4.9% |

(University Schools excepted)

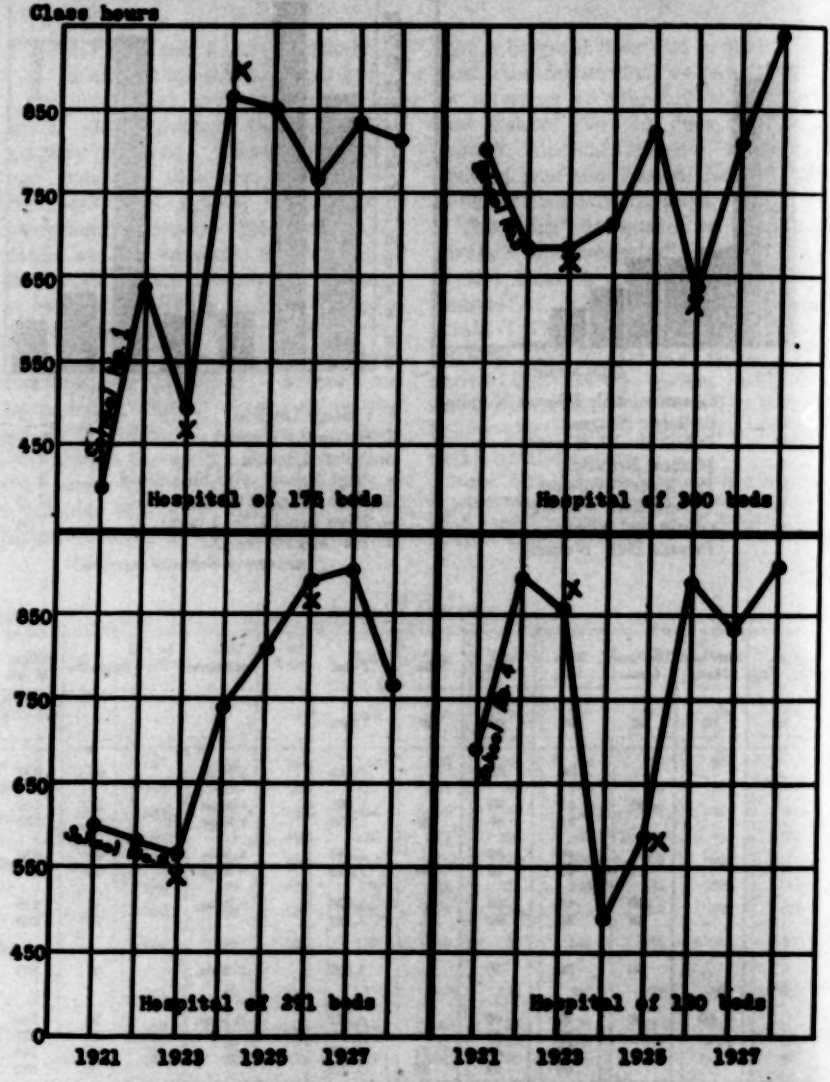
CHART I (continued)

| Eye, Ear, Nos. | Nur. and Mas. | Tbc. and Con. | Dist Hls. | Ven. | Hos. | Total | Affiliation | Students | Class Hours |
|---|---|---|---|---|---|---|---|---|---|
| 20 | 60 | 60 | 60 | 90 | 60 | 1,620 | | | |
| .. | .. | .. | 20 | 60 | .. | 1,615 | 3 Mos. | 60 | 907 |
| .. | .. | 60 | 42 | 90 | .. | 1,161 | 4 Mos. | 37 | 670 |
| .. | .. | .. | 31 | 85 | 20 | 1,122 | 4 Mos. | 31 | 735 |
| .. | .. | .. | 45 | 60 | .. | 1,140 | 6 Mos. | 46 | 624 |
| .. | .. | .. | 60 | 60 | 60 | 1,210 | 4 Mos. | 33 | 722 |
| .. | .. | 120 | 45 | 60 | .. | 1,120 | 4 Mos. | 44 | 840 |
| .. | .. | 30 | 30 | 90 | .. | 1,117 | ..... | 70 | 805 |
| .. | .. | 60 | 30 | 70 | .. | 1,027 | 6 Mos. | 37 | 904 |
| .. | 60 | 60 | 30 | 90 | .. | 1,110 | 6 Mos. | 98 | 720 |
| .. | .. | .. | 60 | 60 | 90 | 1,020 | ..... | 40 | 660 |
| .. | .. | .. | 30 | 60 | 21 | 1,120 | ..... | 87 | 940 |
| .. | .. | .. | 60 | 84 | 30 | 1,015 | ..... | 30 | 631 |

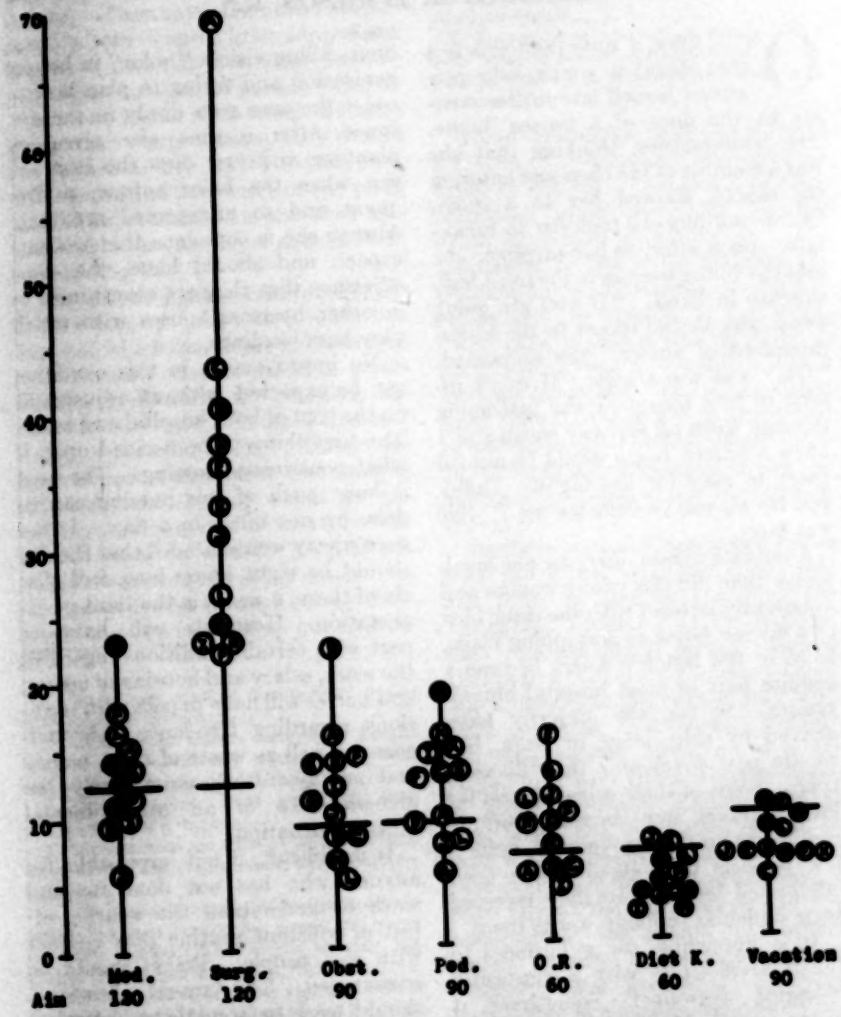
available per student in each school.

June, 1929

To follow the reported class hours through the years makes an interesting study. Where there is a radical change in number, we find that change of personnel is responsible. The graph follows the advent of a new principal of the school. The cross indicates her arrival. The line between crosses represents her work, so far as the curriculum is concerned.




Advent of new Principal indicated by cross
Reported class hours for eight years




Average days of practical experience in each service available per student, in 12 different schools of nursing (A-L) in Ohio; if all students shared equally

# The General Duty Nurse[1]

ELIZABETH M. JAMIESON, R.N.

ONCE upon a time (and this is a true story) a young lady presented herself late in the evening at the door of a nurses' home. The housemother, thinking that she was a member of the class just entering the school, showed her to a room. In the morning she took her to breakfast. Soon after, to her surprise, she met the young woman in the front hall, suitcase in hand. "If you are going away, you should report to the superintendent of nurses," she exclaimed. "Oh," was the answer, "I don't intend to be a nurse. I was just going through town on my way south and I knew a nurses' home would be a good place to stay for the night. Thank you for all you've done for me." She was gone.

Graduate nurses, tarrying not much longer than did this young woman and apparently imbued with the same idea of a nurses' home as a stopping place, have in the last few years become a definite part of most hospital organizations. So far, the majority have arrived by ship, stage or train, but we are now developing the "flivver" type. Some of these nurses travel for love of travel, some because working conditions need improvement, quite a few because they should have been eliminated long before they received their diplomas; nobody wants them.

It is impossible for a business to function efficiently with a constantly changing personnel. Sometimes it seems remarkable that hospitals carry on even as well as they do. The public protects itself, as far as possible, by the special nurse and protests when it cannot afford this luxury. The superintendent of nurses wastes untold hours filling visible "holes" in her organization and trying to plan how to cover the ones seen dimly in the distance. After a time she gives up planning and just does the best she can when the holes appear, so frequent and so unexpected are they. Always she is conscious that patients expect, and should have, the same efficiency that they are accustomed to in other business houses with which they have dealings.

No improvement in this condition can be expected without adjustment on the part of both hospital and nurse. The first thing to be decided upon is what constitutes nursing. The next is how much of this nursing can be done by one nurse in a day. It has been pretty well conceded that the day should be eight hours long and that six of these, a week, is the limit of expectation. Hospitals will have to part with certain traditions regarding the work, salary and housing of nurses, and nurses will have to part with traditions regarding free-lance independence, as well as waste of time, money and energy. Both must study the give-and-take of an unsentimental business situation.

It is difficult, if not impossible, for anyone who has not done hospital work to understand the wearing effort of constant routine plus contact with sick people. Travel should be encouraged. The travel, however, should lead to something. Aimless travel is a useless expense and may become mere "tramping."

Student nurses read about nursing in all parts of the world. They hear about nurses who have been in many countries and they naturally see an additional lure in their chosen work, an advantage over other activities

[1] Reprinted, by permission, from the *Pacific Coast Journal of Nursing*, June, 1920.

selected by their friends in high school. They have a right to look forward to travel, and a little adjustment ought to make it not only possible for them, but should permit them to retain the ideals with which we send them out. As graduates, they should be helped to live up to a standard. The reputation they leave in one place should be available for the next employer, and the employer should insist on knowing it.

The following discoveries were made in reviewing the past year in a 215-bed hospital which has received numerous letters from nurses in different states making application for positions because friends have told them that it is "a good place to work." Hence, we can be modest enough to feel that, in spite of drawbacks of which we are not unconscious, it is at least, not an "awful place to work." Neither do we feel that our geographic position on the line of travel through sunny California was the cause of all our difficulties.

1. An average staff of twenty-four graduates has been "maintained."

2. About sixty nurses have been taught hospital routine, the way to the dining-room and all the other details of adaptation.

3. Eleven nurses were employed long enough to have a vacation.

4. Seven nurses are with us who were here one year ago. Several of these have been here four years.

5. The average number of resignations per month has been five for day nurses and seven for night nurses. The length of stay has ranged from a few hours to a year.

6. In the month of June, eighteen nurses left and thirteen were taken on. The other five could not be replaced, although they were badly needed.

7. Many nurses gave no notice. Most of those who did not do so, dropped out when the work became heavy, thus leaving it considerably heavier for those left behind. Many who gave notice, immediately became useless. Some had to be dropped because they seemed to have come to tell us wherein we lacked perfection. They found fault with everything and everybody, even before they could have had time to become acquainted with work, people or system.

8. Four of those who left us, married; four more went to better positions; while the remainder removed to other towns or went back to private duty.

These graduates have come from all parts of the country and from all types of schools. One result of their migration must inevitably be the death of school exclusiveness. The reputation of the nurse becomes dependent on her individual standard of ethics and the quality of her work. Caps, pins, diplomas lose all value in the eye of anyone who watches such a procession pass by. The will to do her best, find interest in her patients, and be able to see beyond the plainly obvious flaws in any organization, are the qualities one hopes to find in each new arrival.

On the other hand, one is well aware that the nurse who has gone from one place to another searching the "possible," expects only the impossible. She has found herself required always to work on an emergency basis. She knows that she cannot stay with work done on that basis. Nobody can, and nobody but a nurse is expected to do so. Other workers—even in hospitals—make lifetime jobs of their work, but few nurses can do so even if they would like to. I confess that ever since my days of training, I have envied the nightwatchman, the housekeeper, the porter, and others higher up who by some mysterious witchery have succeeded, in every institution, in choosing their own pace and sticking to it, winning, apparently, consideration and respect, to say nothing of pensions.

The following suggestions are offered in the belief that they are constructive:

1. Make living quarters "livable." Encourage nurses to spend enough money to add

simple decorations which are individual and therefore represent home to each. A wiser thing, if it is practicable, is to give enough salary to permit living in a self-respecting way outside.

2. Make hospital jobs possible by limiting the number of patients to a standard decided upon by doctors and nurses, not a standard set by persons who have never taken care of patients. In our own experience in this hospital, we have had orders written for one patient, the carrying out of which required five hours of one nurse's working day.

3. Start with a minimum salary and increase every six months, or annually—not for "staying," but for (a) character, (b) good care of patients, (c) interest in her own progress, (d) capacity for minding her own business and keeping her mouth closed about that of other people.

4. Provide opportunity for legitimate travel. Some of the clinics of large public and university hospitals now stuffed with students should be available for graduate instruction in bedside nursing, supervision and other branches. The large hospital not only has public funds but it also has opportunities for teaching which would improve greatly the quality of service given by the nurse who has already mastered a basic technic and needs only to keep it up-to-date and add to her knowledge. More numbers of beds do not make good nurses. Young people do not grasp as well as do the more mature the essentials in a large field. Sometimes they are overwhelmed by its mere size and lose ideals of personal service. The same field would yield much more to them if they mastered the basic technic in a smaller one and widened their horizon in a large one, after they had had time to think things out for themselves, and had acquired the essential "feeling of need" for more knowledge.

5. Arrange the nurse's transfer to these clinics. Let her have an honest course of instruction in addition to her salary as a general duty or staff nurse. Give her something to take to the next place.

6. Make the minimum stay in each place two years. An occasional turnover is often beneficial to both nurses and hospitals. It sustains interest and keeps institutions alive.

7. Encourage hobbies and study which includes ethics, business psychology, music, art, literature, and craft work. A nurse needs all the beauty and idealism that can be put before her to counteract the depression inevitably a part of constant contact with abnormal bodies and minds.

8. Help her to develop a philosophy of life. Bedside nursing, however scientifically done, is intrinsically material and barren without ideals.

9. Do not tolerate cheapness, loose living or personal vices just to get the work done. Let us not expect the cheap and the fine to mix well together.

10. Abolish the term "general duty." It is undignified and suggests "a little of everything and not much of anything." "Floor nurse" somehow gives the idea of scrubbing or some ungraceful contact with the floor. "Utility nurse" is worse. "Group nurse" is not possible. "Staff nurse" represents something more dignified and substantial, but even a better name may be suggested. Surely one can be found.

11. Try to grade our practical instruction for students that more pride may be stimulated in ability to care for really sick patients. One graduate defined an "awful place to work" as one in which "all the sickest patients were assigned to graduates, while the easy ones were given to the students." Is there any other line of work in which experts have no incentive to show their skill?

12. Establish a staff nurses' section in our organization and bring a group consciousness and responsibility to a steadily growing and now neglected body of graduate nurses.

We are developing the mind of the nurse to a state in which lack of mental stimulus is going to mean disappointment and dissatisfaction. One young private duty nurse expressed this unconsciously when she remarked wistfully, "I feel so far away from all instruction." In contrast, consider another graduate who, preparing for an examination, asked for a list of books suitable for study. As she lived in a hospital staffed with graduates, it was suggested that some of them might be borrowed there. "Oh, no," she said, "they are graduate nurses, you know. They wouldn't have books." What a waste of time and effort on the part of students and instructors if the State Board examinations must be the end!

There is no dearth of young nurses who enjoy caring for patients. Many of them prefer hospital nursing. Let us help preserve this love of their

work. It may be a life work. Let it be joy, not drudgery! Let it mean progression, not decay! Dr. Osler, who saw so clearly the value of travel and study for the medical profession, has said: "In institutions, the corroding effect of routine can be withstood only by maintaining high ideals of work." Nurses, no more than doctors, may escape the effect of routine, and because of its continuity even more than doctors, do they need the advantage of change accompanied by travel and study.

It is obviously our duty to do more than we have yet done for the nurse who is, herself, unaware that she is one of the most important factors in the quality of public service for which our institutions stand today.

# Central Schools of Nursing

## *In the Middle Atlantic Division of the American Nurses' Association*

MABEL F. HUNTLY, R.N.

THE accompanying chart was exhibited at the Convention of the Middle Atlantic Division, on April 25, 1930, during a program on "Centralization." The original chart was compiled by the students in the School for Preliminary Courses in Nursing in Philadelphia, as a project in their class in the History of Nursing, and is based upon the answers to a questionnaire which was sent to the five central schools which are listed.

I

| Location | When Started | By Whom Started | Reasons for Centralization | Executive Control | Number of Schools Affiliated |
|---|---|---|---|---|---|
| Scranton, Pa. | 1920 | Three hospitals | Need of instructors | Supt. of hospital schools | Three |
| Washington, D. C. | 1924 | League of Nursing Education | Need of laboratory facilities | Supt. of nurses and Instructors of Schools. Chairman appointed by League | Six |
| Westchester County, N. Y. | 1920 | Five hospital schools | Need of instructors | Supt. of each school and Educational Director of Central School | Five |
| Utica, N. Y. | Sept., 1923 | Five hospital schools | To improve instruction and equipment and for better organization and increased economy | Bd. Director, Principals of Tr. Schs. Supt. of Public Schs. Rep. from Boards of Trustees | Three (started with five) |
| Philadelphia, Pa. | Feb. 1923 | League of Nursing Education | Belief that centralization increases efficiency and is more economical. Need of teachers and laboratory Facilities | Rep. from Phila. L. of N. Ed. Instructors' Asst. of L. Assn. of Hosp. Supts. Pres. Board of T. Assn. Supts. of Hosp. Sch. of Nursing. Members at large | 1922-11 1929-5 |

II

| Location | Where Classes Are Held | Teaching by | Salary Basis | Expenses Met |
|---|---|---|---|---|
| Scranton, Pa. | Central classrooms in the heart of the city | One nurse instructor | Monthly salary from each hospital | Divided between three schools |
| Washington, D. C. | George Washington University Medical School | Majority of subjects taught by Medical Faculty | | Tuition fee for laboratory courses only, paid by students |
| Westchester County, N. Y. | Bloomingdale Hospital, White Plains | Nurse teacher as Ed. Director | Full salary | Divided between five hospitals |
| Utica, N. Y. | Utica Boys Academy. Rooms set aside and equipped for Central School | Nurse teachers | Educational Director, full time; others part time | Private funds |
| Philadelphia, Pa. | Drexel Institute | Nurse, teachers and Drexel Faculty | One full time salary and others part time | Tuition fee of $60, paid by hospital |

III

| Location | Subjects Taught | Educational Entrance Requirement | Is the Plan a Success | Prospects of Continuation |
|---|---|---|---|---|
| Scranton, Pa. | 1st yr., Sciences except Chem. and Physiology<br>2nd yr., Dermatology, Nervous and Mental Diseases, Communicable Diseases<br>3rd yr., all subjects | Completed by each school | Yes, in some respects | No |
| Washington, D. C. | 1st yr., Sciences<br>2nd yr.<br>3rd yr., Obstetrics, Psychiatry | High school graduate | Yes | Yes |
| Westchester County, N. Y. | Sciences of the Preliminary Term and History of Nursing | High school graduation, with few exceptions | Yes | Yes |
| Utica, N. Y. | Subjects of Preliminary Course, including Principles of Nursing | One to four years high school | Yes | Yes |
| Philadelphia, Pa. | Those of Preliminary Course, except Principles and Practice of Nursing, Hosp. Ethics, and Personal Hygiene | Two years high school | Yes | Yes |

## *Beware of the Three-leaved Plant!*

THE plant whose leaves appear in clusters of three may well give pause to all those who are tramping in the country these warm summer days. Poison ivy may be identified by this sign, and those who know themselves to be susceptible to it, or not keen to run the risk of rhus dermatitis (ivy poisoning) should give this plant a wide berth.

It is the resinous sap that causes the trouble if and when any part of the plant is crushed or broken. While cases of ivy poisoning usually can be traced to direct contact with the plant itself, it is quite possible to be affected indirectly, for the sap can be carried on the fur or body of animals, on farm implements, golf sticks or balls, on clothing, shoes, and even in droplets on the smoke coming from its burning branches.

When one is known to have come in contact with this plant, especially one who is known to be susceptible, washing the hands as soon as possible with a good lather of soap is of some benefit, since the poisonous sap is not soluble in water and cannot be removed by that alone. When the first symptoms of redness and itching of the skin appear, sometimes from one to several days later, a physician should be consulted who will treat with either some oxidizing agent which will react by neutralizing the poison, or by some substance which will dissolve the poison and so aid in removing it.—*Connecticut State Department of Health Weekly Health Bulletin.*

# Centralized Service

GWENDOLYN WEBER, R.N.

CERTAIN basic and fundamental problems are more or less common to all hospitals. One, which in my estimation has manifested itself more so than others, is the rendering of efficient service to the doctors when they visit the floors. In our hospital we believe we have solved the problem by establishing centralized service on each floor, the underlying principle being to quickly give efficient service. This is a practical system and has been greatly commended not only by the doctors, but by the graduate nurses and student nurses.

One student nurse, assisted by a student relief nurse, is in charge of the room which has become one of the most useful and most popular places in the hospital. No one but the student in charge is allowed in the room. We have one Junior nurse and one Freshman nurse in charge, so that one or the other is there at all times. A locked gate, with a broad table-like top, keeps out all others who might (accidentally) disarrange things.

The term Service Room, is used, because that is what one gets there—service. Whether it be a doctor wanting a spinal-puncture tray, or a student wanting hot-water bags and an ice cap, each request is immediately filled. Everyone has the habit now of going to the Service Room for everything needed.

The room was originally a sterilising room; therefore, it is conveniently equipped with an instrument steriliser, one hot-water steriliser and one cold-water steriliser, a lavatory, and a closet.

On the shelves, we have ready for use the following trays arranged in order given:

SHELF I

(a) 2 Surgically Clean Vaginal Irrigation Trays
- 1 irrigating can and tubing with stopcock
- 1 douche tip
- 1 waste basin
- 1 rubber sheet covered with hand towel
- 1 pitcher for extra solution, when required
- cotton balls in pan (for lysol cleansing solution)

(b) 1 Sterile Vaginal Irrigation Tray
- same equipment wrapped in sterile wrappers

(c) Perineal Irrigation Tray
- 1 irrigating pitcher
- 1 waste basin
- 1 can sterile cotton balls
- 1 pair dressing forceps in lysol solution

(d) 3 Sterile Catheterization Trays
- 1 basin for urine
- 1 basin with cotton balls for lysol solution
- 1 waste basin
- 3 catheters
- 4 cotton balls for drying patient
- 2 sterile towels

(e) 2 Colonic Flushing Trays
- 1 irrigating can with tubing, stopcocks, Y tube, and rectal tip
- small jar vaseline
- few sheets of toilet paper
- rubber sheeting covered with hand towel
- waste basin
- pitcher for solution

SHELF II

(a) 2 Dressing Trays
- 1 bottle alcohol
- 1 bottle benzine
- 1 bottle ether
- 1 bottle collodion
- 1 bottle peroxide
- 1 bottle picric
- 1 bottle merbrochrome
- 1 bottle iodine 3%
- 1 bottle argyrol 10%
- 1 bottle silvol 15%
- 1 bottle compound tincture benzoin
- 1 jar vaseline
- 1 jar zinc oxide
- 1 jar unguentine
- 1 shaker boric powder
- 1 shaker zinc stearate

1 package of applicators
1 package of sterile instruments
1 pair sterile gloves
1 instrument basin (sterile medicine dropper)
2 sterile towels
sterile tongue depressors
non-sterile tongue depressors
6 folded pieces of newspaper for waste

(b) Thermometer Tray
3 small glasses for green soap, alcohol, bichloride
1 can with clean cotton balls
1 can for used cotton balls
4 mouth thermometers
1 small jar vaseline
2 rectal thermometers

(c) Hypodermic Tray
1 can sterile cotton balls
1 jar alcohol
1 jar sterile water
1 long basin containing all hypodermic syringes, 6 needles and alcohol to cover
1 alcohol lamp, matches, etc.

(d) Ear Irrigating Tray
1 irrigating can with tubing, stopcock, and glass irrigating tip
2 large emesis basins
cotton balls
sterile towels

(e) Eye Irrigating Tray (Sterile)
2 small basins full of cotton balls
1 waste basin
dry cotton balls
emesis basin

(f) Eye Fomentation Tray (Sterile)
2 enamel basins containing gauze compresses
1 waste basin
cotton balls

(g) Throat Irrigating Tray (Sterile)
irrigating can with tubing and stopcock
irrigating tip
2 large emesis basins
cello-wipes
pitcher for extra solution unnecessary

SHELF III

(a) False Teeth Containers
(b) Empty Bottles
(c) Thermometer Glasses
(d) Hypodermic Trays
(e) Physical Examination Tray
1 large sheet
2 hand towels
tongue depressors (sterile and unsterile)
applicators (sterile and non-sterile)
tape measure
1 waste basin
cotton pins
gloves (sterile and non-sterile)
flashlight, etc.

(f) Vaginal Examination Tray
1 sheet
1 pair sterile gloves
1 can powder
K-Y lubricating jelly
vaginal speculum
applicators (sterile and non-sterile)
glass slides

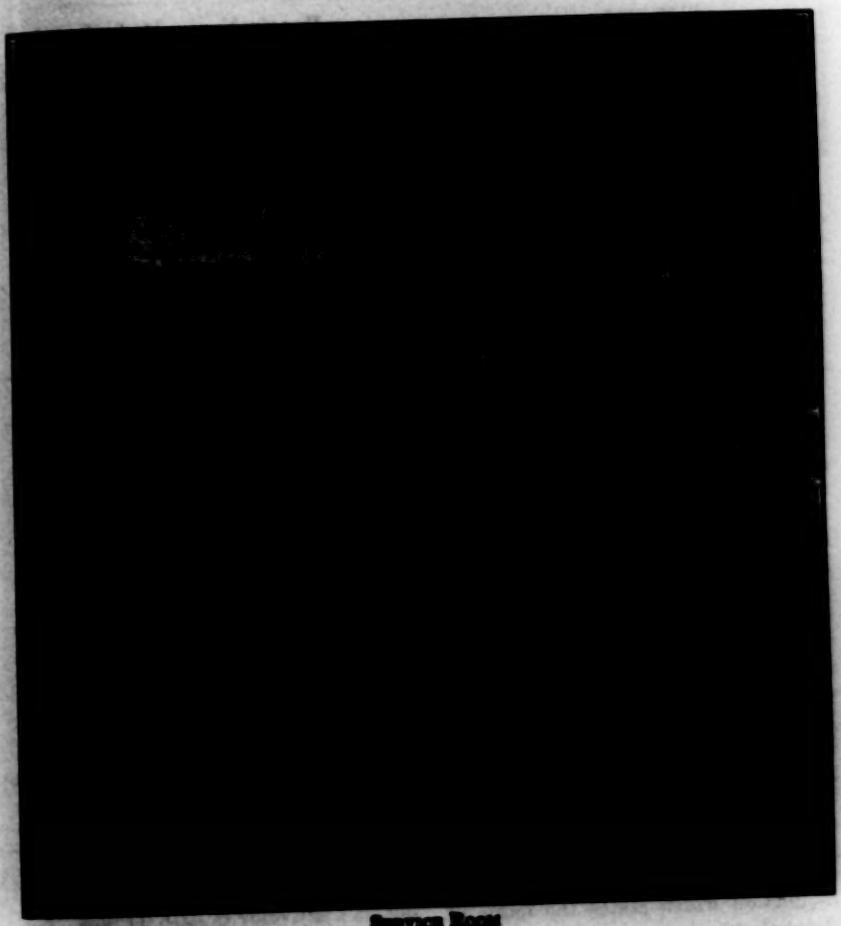
(g) Rectal Examination Tray
1 large sheet
K-Y lubricating jelly
gloves (sterile and non-sterile)

(h) Spinal Puncture Tray
1 small bottle 95% alcohol
1 small bottle iodine 7%
1 small picric 4%
1 small bottle mercurochrome 4%
1 small bottle collodion
1 waste basin
4 sterile towels
sterile applicators
sterile cotton balls
roll of adhesive
3 sterile test tubes
sterile needles
manometer
1 sterile gown
1 pair sterile gloves

SHELF IV

(a) 6 Proctoclysis Cans
(b) 2 Intravenous Trays (2)
1 cannula with tubing, stopcock, and adapter (sterile)
2 sterile needles
2 sterile applicators
2 sterile cotton balls
one sterile compress—to cover cannula
1 small bottle iodine 7%
1 small bottle alcohol 95%
1 small bottle collodion
1 waste basin
adhesive
rubber sheet covered with towel
tourniquet

(c) Hypodermoclysis Tray
cannula with tubing, stopcocks, y tube, and adapters (sterile)
2 sterile needles
sterile compress
sterile towels
sterile cotton balls
small bottle collodion
small bottle alcohol 95%
small bottle iodine 7%
1 small roll of adhesive
sterile applicators



Service Room

basin of solutions

(d) Lavage Tray
- 1 gastric lavage apparatus
- 1 basin for ice
- 1 pitcher for solution
- 2 emesis basins
- 1 large rubber sheet
- cello-wipes
- hand towel

(e) Stupe Tray
- 1 small basin
- 4 cotton balls
- 1 part turpentine
- 3 parts of oil
- 1 waste basin

large piece flannel (moist and hot)
large piece flannel (dry)
1 abdominal binder
4 safety pins
2 hot-water bags—one-third full of water

On the door opening into the closet, we have the following equipment hanging on hooks that have been placed through white oilcloth which covers the entire door:

24 hot-water bags
12 ice caps

10 air rings
18 gauze bags

We keep a reserve supply of equipment on the shelves in the closet in addition to some other articles which are greatly in demand, such as:

| | |
|---|---|
| compresses | bed pads |
| combinations | extension cords |
| cello wipes | bandages |
| alkoln rubbing lotion | rubber aprons |
| tongue depressors | ice cap covers |
| light bulbs | hot-water bag covers |
| adhesive | peak blankets |
| paper cups | rubber sheets |
| safety pins | perineal pads |

There is also a crushed-ice container in this room in which we keep, in a metal can, all the medications which must be kept cool. All hypodermics are prepared in the Service Room; therefore, the narcotics are kept in the locked drawer of the work table.

What consolation it is to know that every tray is in readiness for use! We also know that every hot-water bag, ice cap, air ring, and in fact every other rubber article is thoroughly lysolized or carbolized after having been used for a patient. The trays are waterlilized or, if only surgically clean, are boiled immediately after use. While the nurse in the Service Room is getting the tray from the shelf, the one who wants it checks a requisition which states the name of the patient, room number and the name of the nurse taking the tray. In this way all equipment is carefully accounted for.

At night, the Junior nurse on the floor is responsible for the room. All equipment is checked over once a week by the supervisor on the floor.

### *Heroic Nurse-Midwife*

WE had a big flood Friday and Saturday night—the biggest I've ever seen here. It smashed everything along the banks of the river on each side, including the swinging foot-bridge at Hyden. It started at noon on Friday. The river was so low your could almost have waded across the ford, but by 6 o'clock it was rising rapidly. At 9 that night, a man came for me from Wolf Creek. He had to swim down the road from the mouth of Camp Creek part way, and we couldn't get back that way at all; so we went up Hurricane Creek and struck a new trail to Wolf—the most terrible trail I have been over and in the worst storm.

Needless to say, the baby was born when we arrived, but as the father had come all that way for me, I couldn't but go back with him—but it was the worst trip I had. We even had to swim Camp Creek four times, and he waded up to his neck nine times in all.

Well, I got back next day. I had to leave the things on Camp Creek and walk back beyond the school and down to the mouth, where I had hitch. It was a sight to see. The river was up to the B's front gate—hardly a treetop in sight, and all the bottom fields a sheet of water. Well, after lunch I walked up high on the mountain and waded waist deep across Hurricane, with Tom H. and Jim M. carrying the mail-bags and all of us holding hands.

I got home at 2:30 p. m., and had just got bathed and was falling off to sleep, when Minton came up and said if I would go across the river to the M's, one of the men would take me over. It certainly wanted the movie camera to finish that picture. I tell you it was exciting. To start with, they had to take the boat out of the bottom, and Lonie and Jayhugh and Tom and Jim carried it to a good starting place, and Jim took me over. The moon was high by this time. Five men were on the other side, on a raft, ready to catch the rope. But the river was so swift the boat skimmed past like a piece of driftwood. But Jim is a cracker of a boatman and headed us safely, every lick below the ford right into the M's bottom field, arriving in time (9 p.m.). I got an eleven-pound boy at 2, Sunday morning. So everyone is happy. —Dede Fast, R.N., Certified Midwife. (Excerpt from a letter to the Director, March 28, 1929. *The Quarterly Bulletin of the Frontier Nursing Service, Inc.*, June, 1929.)

# *Eminent Teachers*

## Ethel J. Odegard, R.N., M.A.

STELLA ACKLEY, R.N.

ROBERT BROWNING said: "A man's reach should exceed his grasp." The quotation gives the key to Ethel J. Odegard's success as a teacher. Parents such as hers, of Norwegian extraction, give heritage, but the individual and the environment must complete the impetus.

It was this inward reach, no doubt, which actuated her when she entered Dr. Ravn's Hospital, Merrill, Wisconsin, after completing the home high school course. Later, contact with graduate nurses from larger hospitals stimulated the desire for a postgraduate course at Michael Reese Hospital, Chicago. Here the horizon widened and in 1914 she went to the University of Wisconsin where, with a major in science, she received her bachelor's degree four years later.

With this preparation she started out to obtain experience in teaching in schools of nursing. Eventually she sensed the possibilities of centralized teaching, because she chose the position as Director of Nurses at the Mary Lanning Memorial Hospital, Hastings, Nebraska, where this contact was accomplished.

Up to this point the emphasis seemingly had been placed upon theoretical nursing but now the opportunity for a more practical development came and she accepted a position in Madison, Wisconsin, in 1921 at the Madison General Hospital as Assistant Superintendent of Nurses.

ETHEL J. ODEGARD, R.N., M.A.

Miss Odegard could have continued in such work but the urge within her for another type of administrative work, that of establishing centralized teaching and standardizing nursing education, was too strong. Therefore, when the Milwaukee Council of Nursing Education offered her the directorship of the Central School in 1924, she accepted it. This position she still holds, having had a leave of absence during the last semester to complete work for the much coveted master's

degree from Teachers College, Columbia University, which she had striven toward through several summer sessions.

One is tempted to ask, "How soon will she reach for a doctor's degree?"

The profession of nursing supercedes all other interests with Miss Odegard; even her own interests are secondary. Its ideals are her ideals and she is tireless in trying to obtain the best for the group. She has given and is still giving of herself to her state, as is proved by the fact that she is president of the Fourth and Fifth Districts Association, she is an active member of the Wisconsin League of Nursing Education, and she also belongs to the American Association of University Women. She makes the most of the professional magazines, quotes them and discusses them intelligently.

Her outside interests are cultural, she likes good literature, and has a real appreciation of good music. Although she approves of tennis, golf and other outdoor activities for her students, one feels that she herself has not had much time for these active sports.

As an instructor, she is dynamic; she has vision and although exacting with her students, she is not partial. A high standard of scholarship is expected. Being ambitious herself, she instils the essence of adult education into every soul where a mere fraction of receptivity may be found. Of all of the subjects in the curriculum, she prefers bacteriology, anatomy and physiology. She is particularly skillful in teaching dissection. Her students will tell you that they must be particularly careful of detail in their work; extremely conscientious herself, she demands the same from them.

Irregularities in class work and attendance are checked and records are carefully kept. We have found her eager in her work and coöperative. Miss Odegard does not wait to have new types of examination questions thoroughly proven before trying them, for she is not afraid to launch forth upon different methods. Do we need to add that this makes for teaching growth?

Supervision is a subject lying close to Miss Odegard's heart. She is interested, too, in improving and developing certain general courses, and feels that there is a wide opportunity to enrich curricula through teaching sociology, psychology etc.

Since arriving in Milwaukee, publicity has received much of her attention, first for the Central School and secondly for the nursing organizations. With this in mind, she has established contacts with the Council of Social Agencies, the Civic Welfare Committee, and many others. At present she is working on a plan of financing the Central School which will take care of growth and expansion. Shall it be university affiliation or shall it set up an independent unit of college grade?

Much of her path has been made easy by her pleasant personality. This, with an appreciable amount of stick-to-itiveness, has enabled her to carry through any project once determined upon. Her preparation makes it possible for her now to do what Longfellow has so well expressed:

> Reclined upon a sea of Thought,
> Still unattained the land it sought,
> My mind, with loosely hanging sails,
> Lies waiting the auspicious gales.

# Editorials

### *Welcome—I. C. N. Visitors!*

*ALTHOUGH the Canadian nurses are the cordial official hostesses of the nurses of the world, this summer, many American nurses are eagerly anticipating the privilege of being incidental hostesses, as it were. Those whose happy fortune it has been to entertain some of the early arrivals already know the joy of beginning international friendships. Hundreds of others await the opportunity. You come bearing gifts—you splendid nurses of other lands—the gifts of friendship, of understanding, of knowledge of our common purposes.*

*We of America reciprocate by opening our doors and our hearts to you. When the Congress is over, we shall expect you. You will find that you are welcome, thrice welcome, in "the States."*

### *Grading*

THE nurses at "370" are fairly bursting with pride in the profession it is their happy privilege to represent, for Dr. Burgess reports a splendid, indeed an almost phenomenal, response to the challenge of the first Grading. It would be phenomenal from any other group. Not since the days of the great war, when nurses arose en masse to answer their country's call has anything so truly inspiring occurred in the profession, for again nurses have responded nobly, fearlessly, to a ringing challenge. By the end of Grading Week the reports began pouring in and, as this is being written, early in June, more than 1200 schools have sent in their analyses of their work. The diagram on page 824, prepared by Dr. Burgess, shows this extraordinary accomplishment.

The staff of the Grading Committee office is more than fully occupied with the task of filing the enormous mass of material preparatory to the arduous task of examining, checking and making the evaluations on which the first confidential ratings will be based. The volume of material is so enormous that over-size folders, in large quantities, have been put into use. This is the first time in more than two years that the *Journal* has appeared without an article written in that busy office. The reason is obvious. Dr. Burgess and her staff are wholly engrossed in Grading, the task for which the Committee and its staff, the hospitals and nurses of the country, have been preparing through many months.

To be sure there are directors of hospitals and of schools who are reported to have expressed complete indifference to, or even active resentment for, the plan of Grading. That, of course, was to be expected. A one hundred per cent response to the first call would have been beyond the bounds of reasonable possibility. Human nature does not permit a one hundred per cent response to anything. It was to be expected that some of the forms would be tossed into waste paper baskets.

The really significant thing is not that the response was so voluminous but that it was done in a spontaneous and splendid fashion, both by hospital superintendents and by the principals

of the schools. The volume of work involved in large schools was enormous but we are told that many of them sent early reports. Dr. Burgess permits us to quote from a few of the cordial letters chosen at random from those which accompanied the returns. They justify all that the most optimistic of nurses believe of the capacity of their profession for courage, tireless devotion, and desire to go forward. We quote from two:

In order to have duplicates for our files, we have had the large forms photostated. We wish to give them further study because of the definite picture they present of our work.

I am very glad that we have had this personal survey. At first we thought it was too dreadful to think about, it seemed so overwhelming, but after going over it a number of times and sorting it out, it did not seem so overwhelming after all. . . . We are all looking forward very keenly to the result, to know for sure where the weak points are. We discovered some ourselves that otherwise would have remained hidden.

These letters are so typical of the spirit of all, for many laboriously copied the data for their own use, that the prediction confidently may be made that, if the Grading Committee were obliged to drop its work at this point, schools of nursing would nonetheless start on an upward path because of this self-analysis.

From Sisters, from doctors, from lay superintendents, from nurses, the letters have come bearing the appreciation of the writers for the privilege of participating, complimenting the Committee on the excellence of the forms sent out, indicating some of the immediate values of this first study, and pledging further support to the movement. We are told that one of the striking features of the returns is that confidential reports have been requested for very many board members.

With heads up and banners flying the nursing profession has fallen into line and is preparing to march forward as gallantly as any unit which sailed for France in the days of the greatest test our profession had previously faced. It is glorious to know that we do not march alone for the letters of the hospital superintendents, we are told, are as enthusiastically coöperative and forward-looking as are those of the directors of our schools, the gallant captains of our army.

### *The Alumnæ and the New Principal*

THE diagrams from the files of the Ohio Board of Nurse Examiners on page 832 are significant. They, and others like them, indicate clearly enough that schools of nursing do not remain "on an even keel" through the crisis of changing principals. Recalling the statements in "Nurses, Patients and Pocketbooks" on the subject of frequent changes, the wonder is that some of the schools survive at all. How can that one, recently reported to us, which has had sixteen changes in two years, be anything short of a wreck? If the whole truth were known, probably it would be discovered that the position, and others like it, is untenable and that there should be no school in such institutions.

In a state whose schools are still fairly close to the pioneer stage, the Educational Director sighed: "It is not only the frequent changes of administration that make our problem of improving the schools so difficult, but the attitude of the members of the Alumnæ Associations troubles us almost as much. They so often complicate the situation by mistaken loyalty to one who is being replaced, even when the vacancy was created at her own request."

Such nurses forget that, if those who have won their loyalty and affection were really worthy administrators, they worked in the spirit of that well known principle of administration, "Work always for your successor"; that is, "Leave any piece of administrative work in a stronger position than that in which you found it!" The worthy administrator tries to leave an efficient organization behind her. It is the unworthy one who encourages her faculty to leave with her. This, of course, does not absolve the staff from the responsibility of making personal decisions. It does relieve them from the dreadful dilemma, so often forced upon them, of having to choose between a personal loyalty and one to a larger principle involving the welfare of the patients in a hospital and the progress of students in a school.

The arrival of a new principal should be a time of heart-searching for an alumnae association, for a study of the situation of the school in relation to its community and to the profession as a whole, and for a whole hearted support of a new principal if she comes with good preparation and the courage, the vision, the wisdom to build upon all that is best in the tradition of the particular institution.

### *Dr. Fosdick's Message*

WAVE upon wave the uniformed students of the schools of New York went flowing down the aisles and into the pews of the Cathedral of St. John the Divine. Up into the choir and presbytery, past the Red Cross guard of honor, went the graduates and the faculties of the schools, Miss Nutting and Miss Wald heading the line. There, too, were our veteran nurses, they of the Spanish-American War, brave in new uniforms, and the younger women of the Legion, also in uniform, together with the nurses of Henry Street in their friendly blue and gray. Fringing the auditorium were graduates in their white uniforms and other graduates in the black cap and gown of Teachers College.

In due course the sonorous service paused and Dr. Harry Emerson Fosdick rose in the pulpit. Forthright, direct, with brief, deft and moving phrases, he eulogized the nursing profession. Then said he "Were conditions reversed and a nurse were standing here to address an audience composed wholly of clergymen, I am sure the clergy would want from that nurse not eulogy but aids to thinking and to useful living. I am reminded of the peasant and St. Francis of Assisi. You will remember that the peasant, meeting St. Francis by the wayside admonished him thus: "See that thou art as good as the people believe thee to be!"

Dr. Fosdick discussed the principles and the ethics of business and of professions, urged the nursing profession to retain the high ideals of a true profession, and warned especially of the dangers of commercializing a high calling. Again and again he reverted to his theme and closed an unforgettable address with: "I admonish thee to be as good as the people believe thee to be!"

### *Demonstrable Internationalism*

WITH all of our eager planning for the Congress of the I. C. N. in Montreal, nurses must not overlook the equally important international conference which occurred in Atlantic City, June 12-21. There the representatives of the hospitals of some forty countries spent three wholly amicable and fruitful days in discussion of the problems of hospital administration, problems which seem

to be very similar the world around. The Congress was the outgrowth of the work of the American Hospital Association's Committee on International Relations, under the guidance of Dr. S. S. Goldwater, internationally famous hospital consultant and brilliant diplomat. The Congress organized with Dr. René Sand of Belgium in the chair and Dr. Lewinski-Corwin of New York as secretary. Dr. Sand's genius as presiding officer, his extraordinary facility as a translator, his diplomatic gifts, his knowledge of the whole field of public health, made it possible to conduct the business of the Congress with dispatch. Studies of the hospital field were presented by writers from different countries; a constitution and by-laws for a permanent organization were proposed, but it was decided to defer permanent organization for another two years, in order to permit the hospital folk of some of the countries to get ready for participation in such an organization.

The hospitals of Norway, of Denmark, of Switzerland, and of New Zealand were ably represented by nurses—Sister Bergljot Larsson, Sister Clara Feldhaus, Sister Marion Biggenbach, and Miss McKenzie—all of whom will attend the Congress at Montreal.

The Conference closed with the appointment of a committee composed of representatives of each of the 26 countries officially represented. The values of the Congress are by no means confined to the discussions at the meetings. As guests of the American Hospital Association, the delegates toured some of our eastern cities. Foundations for lasting friendships have been laid, friendships of a sort which will add new links to the chain of peace which is tending to bind the people of the world together.

### *At Atlantic City*

WE wanted to hold the pages of this *Journal* for the news of the conventions in Atlantic City, but that was impossible when the Journal staff is making all speed to get this issue out in advance of the Montreal meeting. As this is written, the first sessions of the National League of Nursing Education and the American Hospital Association are closing. Atlantic City is at its gay best; its cool breezes are tempering what would otherwise be torrid heat.

The magnificent new convention hall provides every facility not only for the two major groups, but also for a number of lesser national groups. Under the vaulting blue and silver dome of the great hall are gathered an extraordinarily fine collection of exhibits. The League's educational exhibit is the eyesore of all eyes. Its import is unmistakable. The miniature wards, old and new, strikingly depict not only the change from the chaos of pre-Nightingale days, but also the change from the early days of the Nightingale system to the present scientific method. In perfection of detail are shown the basic principles underlying the nursing practice of today in caring for medical, pediatric, and psychiatric patients.

Another focal point is the display of the Committee on Grading Nursing Schools where eager questioners are observing the latest reports in that study.

At the opening meeting of the League, the President, Miss Burgess, presented the paper to be found on page 705 of this Journal, reminding her hearers that securing legislation is not enough, that it must be administered intelligently by really competent persons. What constitutes

suitable preparation for the members of Boards of Nurse Examiners is a question of great importance to the profession today when schools need so much guidance.

At the opening meeting of the American Hospital Association, Dr. Louis Buntingham, President, outlined the history of the thirty-one years of the organization and foretold some of the future developments, developments which will doubtless be based on research and on the publication of important results as applied to practical problems of administration.

Both associations are swinging into their programs, some of which are cooperative, with enthusiasm. Out of the conferences and the many opportunities for informal meetings and discussions between the two groups should come a deeper accord and an appreciable advance in programs bearing upon the object of both associations—the care of the patient.

### *Essential Hospital Functions*

. . . At the center of this picture, drawn in enduring lines, stands the *patient* and whatever other functions the hospital has already taken on, or in the future will take on, its service will be less valuable unless these functions center around the idea that primarily the care of the sick is the central function of the hospital. In the complexity of its present organization, this fact may be lost sight of unless it is constantly held before us as our chief aim. In this, however, it must be fully recognized at the present time that the care of the sick has expanded so as to include the care of the health of the entire community. . . .

The hospital, as at present organized, should represent the brain center of all these activities which benefit the individual sick and the health of the community within its sphere of influence. It is this central idea that the hospital is primarily a conserver and a restorer of health and that the care of health is its paramount responsibility which gives to the hospital the atmosphere that is as evident as the breathing spirit in our first class institutions. Only in so far as the hospital fulfills this function, does it fulfill its obligation to those who by their generosity and foresight, whether these be private individuals or the state itself, have made the hospital possible. . . .

Unless the authorities who are responsible for the existence of the hospital are able to command sufficiently competent medical service to give such service to the patient, it were better that the hospital did not exist than that it carry on under ill qualified individuals. . . .

Similarly, since the care of the sick and the safeguarding of the health of the community requires highly trained nurses as well as physicians, our hospitals in general have undertaken the development of training schools for nurses and this is accepted as another of its essential functions. Only recently, have a few hospitals felt that it is necessary to take the same step in regard to their nursing schools as they have already taken in regard to their medical teaching of having an affiliation of the nurses school with a university organization. . . .

It is our hope that ultimately even the rural hospitals shall accept in principle these ideals as their aim and that the treatment of patients under their care and the concern for the health of the community which they serve shall be as efficient in its limited field as that found in the larger institutions where the full program is put into effect.—From an address given at the International Hospital Conference, by John A. Hartwell, M.D., President of the New York Academy of Medicine.

# Our Contributors

Elizabeth C. Burgess, R.N., M.A., is President of the National League of Nursing Education and Associate Professor of Nursing Education at Teachers College, New York City.

Dr. Ira I. Kaplan, Radiation Therapist at Bellevue Hospital, New York, based his article on lectures given to Bellevue student nurses.

Ann Doyle, R.N., M.A., spent weeks in careful research before writing the first of her series of articles on the work of the Catholic and Protestant orders in nursing in the United States. The articles will appear in successive Journals. The editors will welcome correspondence.

Office nurses will rejoice to find one of their number producing so excellent an article, as that by Violet Emptage, R.N. Miss Emptage is a graduate of Lenox Hill School for Nurses, New York. Her experience comprises private duty, camp nursing and a postgraduate laboratory course.

Ellen La Motte has devoted many years to the opium question. She has contributed to *Atlantic, Century* and *Harpers*. She is the author of "The Tuberculosis Nurse" also "The Ethics of Opium"; and other articles.

The enthusiasm with which Louis E. Kennedy, B.S., R.N., teaches chemistry undoubtedly is as stimulating to her students as is the device for rousing interest, described in this issue.

Myrtle M. Hollis, R.N., is Supervisor of the Out-Patient Department of the University of Minnesota Hospital.

Since graduating in 1926, Winifred Patrick, R.N., has been head nurse, assistant instructor and director of practical instruction at the Johns Hopkins Hospital.

Mlle. L. Chaptal, who writes vividly of some of the progressive movements in France during the past few years, is President of the national organization of French nurses.

Frances S. Macmillan, R.N., is Superintendent of Nurses and Director of the School of the Methodist Episcopal Hospital, Indianapolis, Indiana.

After graduating from the school of the Highland Clinic, Shreveport, La., Grady Asher, R.N., became x-ray technician for her Alma Mater. For more than two years she has done physiotherapy work.

A confirmed internationalist, best known perhaps for her work as Director of the Division of Nursing of the League of Red Cross Societies, Alice Fitzgerald, R.N., through her work in Siam, has added another brilliant page to nursing history.

Jennie L. Greenthal, R.N., has held many offices in her Alumnae and District Associations. She is Treasurer of the Pension Fund of which she writes. She is a Surgical Assistant and Office Nurse.

Mabel F. Hunty, B.S., R.N., is Director of the School for Preliminary Courses in Nursing, Drexel Institute, Philadelphia.

Caroline V. McKee, B.S., R.N., the Chief Examiner of the Ohio Board, generously shares some of her significant studies of the schools of that state with *Journal* readers.

Elizabeth Jamieson, R.N., is an earnest student of the problems of a nursing service in the hospital. She is superintendent of nurses at Fabiola Hospital, Oakland, Cal.

The American Nurses' Association, in the article on the Relief Fund, takes all nurses into its confidence in its effort to solve the knotty problems of administering the Fund both sympathetically and wisely.

The centralized service described by Gwendolyn Weber, R.N., is that of the Methodist Hospital of Central Illinois (Peoria). Miss Weber is a graduate of the Kansas University School of Nursing and has had work also in the University of California.

Stella Ashley, B.S., R.N., was herself an "eminent teacher" before she became a Superintendent of Nurses.

Deborah Maclay Jensen, B.S., R.N., author of a "Handbook of Case Studies for Student Nurses," is Supervisor of Clinical Instruction in Nursing at the University of Minnesota.

The *Journal's* various articles by Gladys Sellew, R.N., M.A., will undoubtedly have stimulated a lively interest in her forthcoming book on "Ward Administration."

The American Dental Association cooperated with the Education Committee of the National League of Nursing Education in preparing the Outline on page 869.

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY ISHA D. GAGE, M.A., R.N.

# Case Study in Schools of Nursing[1]

DEBORAH MACLURG JENSEN, R.N.

## *Introduction*

WITHIN the last few years the interest in clinical instruction in schools of nursing has been focussed on the case study method. For over fifty years the profession of law has recognized the value of presenting cases for study. It was found that the method developed in the student intellectual independence and individual thinking. Textbooks were used to explain and clarify principles brought out by the cases. Dr. Richard Cabot said, in discussing case study in medicine: "In the best practice the students are required to bring their own powers into play at close range, gathering their own data, making their own interpretations and proposing courses of treatment." In engineering, the method was used to stimulate and encourage the student to exercise his power of independent thinking and to increase his ability to cope with new situations in engineering practice. In many other fields of education, the value of this method of approach has been realized, and today it is also used in social work, dietetics, ethics, and business.

Educators recognize it as a method adapted to stimulate and hold the interest of the student. It inculcates a scientific spirit of independence and investigation. Many years ago students were taught nursing by the study of cases before the ward situation became so complex that the teaching by cases on the part of the head nurse more and more yielded to classroom work under the direction of instructors. The growing complexity of the modern hospital tends to bring about an attitude of mind on the part of the student that patients are mere numbers or the occupants of so many beds. Students do not take time or perhaps do not know how to gather nursing information about patients when ward experience is based on the assignment of routine work, whilst class work remains detached lectures without practical application.

Ward training, after the preliminary period, should be planned to give a progressively graded experience, and it is desirable that students be given the complete care of patients as soon as possible. In 1924, a school of nursing was established at Yale University and to the faculty of this school the nursing profession is indebted for the first developments of case study in nursing. This method is the fundamental teaching principle in all departments in the Yale School of Nursing. During the past five years many other schools have introduced the method, and in an attempt to ascertain to what extent it is being used, a questionnaire was sent to ninety schools this spring.

[1] Read at the annual meeting of the National League of Nursing Education at Atlantic City, June 20, 1929.

*Report on Questionnaire*

FIFTY-FOUR questionnaires, or 60 per cent, were returned; forty-four schools, or 81 per cent of the schools, including twelve university schools, stated that students were writing case studies; and ten schools, or 19 per cent, including one university school, stated that students did not write nursing case studies.

The obstacles given by these nine schools are as follows:

1. The curriculum is too crowded
2. Too heavy nursing demands are made by the hospital
3. Teaching and supervision of case studies cannot at present be added to duties of teaching and supervisory staff
4. No instructor or supervisor with the qualifications and time to direct such studies is available

Five schools merely stated that they had not yet developed case studies.

The program carried out by the schools which have developed the method is as follows:

The number of hours of classroom instruction given in the technic of building up case studies varies greatly.

30 hours are given in 1 school, or 2 per cent of those studied
15 " " " " 6 " " 13 " " " " "
10 " " " " 7 " " 16 " " " " "
6 " " " " 2 " " 4 " " " " "
5 " " " " 2 " " 4 " " " " "
3 " " " " 1 " " 2 " " " " "
2 " " " " 3 " " 7 " " " " "
1 " " " " 9 " " 21 " " " " "
1 hour in each new service given in 1 school, or 2 per cent of those studied
2 hours " " " " " " 1 " " 2 " " " " "

Instruction in case study is included in the clinical subjects in 4 schools, or 9 per cent. Hours were not stated by 7 schools or 16 per cent of those studied.

The course is conducted by:

The instructor of nurses in 19, or 43 per cent of the schools studied
The teaching supervisor in 10, or 23 per cent of the schools studied
The instructor of practical nursing in 6, or 14 per cent of the schools studied
The assistant superintendent of nurses in 3, or 7 per cent of the schools studied
The doctor in 1, or 2 per cent of the schools studied
Not stated in 1, or 2 per cent of the schools studied

Five schools stated that during this course, three hours are given by a member of the social service department.

The course is given to students during the

1st year in 19, or 43 per cent of the schools studied
2nd year in 13, or 30 per cent of the schools studied
3rd year in 3, or 7 per cent of the schools studied
Throughout the whole course in 5, or 11 per cent
The year was not stated by 4 schools, or 9 per cent of the schools studied

The text-books and reference reading used by students in case-study work were given as follows:

Nursing text-books used in 33 schools, or 75 per cent of those studied
Jensen, "Student's Handbook in Nursing Case Studies" used in 4 schools, or 9 per cent
References listed in course on Case Study in "A Curriculum for Schools of Nursing" used in 3 schools, or 7 per cent
*American Journal of Nursing* was used in practically all the schools as a reference.
The student projects conducted during this course were not stated by 26 schools, or 59 per cent
The writing of a case study with analysis of each point in 5 schools, or 11 per cent
The writing of a social history in 4 schools, or 9 per cent

Visits to clinics, patients' homes, etc., in 5 schools, or 11 per cent

Students begin to write case studies

During the 1st year in 29 schools, or 66 per cent
During the 2nd year in 12 schools, or 27 per cent
During the 3rd year in 3 schools, or 7 per cent

The different services in which studies are required is given by these schools as follows:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| General Medicine | 38, | or | 80 | per | cent | of | the | schools studied |
| General Surgery | 38 | " | 80 | " | " | " | " | " |
| Pediatrics | 32 | " | 73 | " | " | " | " | " |
| Gynecology | 28 | " | 63 | " | " | " | " | " |
| Obstetrics | 25 | " | 57 | " | " | " | " | " |
| Eye, Ear, Nose and Throat | 15 | " | 34 | " | " | " | " | " |
| Special Diet Kitchen | 14 | " | 32 | " | " | " | " | " |
| Out-patient Department | 14 | " | 32 | " | " | " | " | " |
| Psychiatry | 12 | " | 27 | " | " | " | " | " |
| Neurology | 9 | " | 21 | " | " | " | " | " |
| Urology | 9 | " | 21 | " | " | " | " | " |
| Contagion | 6 | " | 13 | " | " | " | " | " |
| Operating Room | 5 | " | 11 | " | " | " | " | " |
| Orthopedic | 3 | " | 7 | " | " | " | " | " |
| Tuberculosis | 3 | " | 7 | " | " | " | " | " |

The number of studies required on each service varies from one to six, regardless of the length of time spent in the department. Three schools require one study each month and one school requires one study each six weeks, regardless of length of time spent on the service.

The selection of cases for study is supervised by:

The instructor in 14 schools, or 16 per cent of the schools studied
The ward supervisor in 12 schools, or 27 per cent of the schools studied
The head nurse in 7 schools, or 21 per cent of the schools studied
The instructor in case study in 4 schools, or 9 per cent of the schools studied
The doctor and social worker in 1 school, or 2 per cent of the schools studied
The resident in medicine and surgery in 1 school, or 2 per cent of the schools studied
Not stated by 3, or 7 per cent of the schools studied

The studies are graded by:

The instructor in 20 schools, or 45 per cent of the schools studied
The ward supervisor in 9 schools, or 21 per cent of the schools studied
The head nurse in 7 schools, or 16 per cent of the schools studied
Not graded in 8 schools, or 18 per cent

Case-study conferences are held by 35 schools, or 79 per cent.

As often as necessary in 11, or 31 per cent of these schools
Weekly in 7, or 20 per cent of these schools
Monthly in 3, or 9 per cent of these schools
When each case is selected in 4, or 11 per cent of these schools
Every two weeks in 1, or 3 per cent of these schools
Three times during each study in 1, or 3 per cent of these schools
Not stated by 8, or 23 per cent of these schools

These conferences are conducted by

The instructor in 20, or 57 per cent of these schools
The ward supervisor in 12, or 34 per cent of these schools
The head nurse in 3, or 9 per cent of these schools

Grades are kept on the students' permanent record cards in 26 schools, or 59 per cent; as part of the subject grade in 3, or 7 per cent; averaged with ward grade in 1, or 2 per cent; and were not recorded by 14, or 32 per cent of the schools studied.

The benefits derived by students

from these studies were reported as follows:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Increased interest in individual patient | 23, | or | 52 | per | cent | of | the | schools studied |
| Improved correlation of theory and practice | 12 | " | 27 | " | " | " | " | " |
| Increased interest in reading and studying nursing problems | 10 | " | 23 | " | " | " | " | " |
| More intelligent nursing care received by patients | 9 | " | 21 | " | " | " | " | " |
| Increased observation by students | 8 | " | 18 | " | " | " | " | " |
| Clearer picture of diseases obtained by students | 6 | " | 14 | " | " | " | " | " |
| Increased interest in bedside nursing care of patients | 6 | " | 14 | " | " | " | " | " |
| Increased interest in social side of cases | 6 | " | 14 | " | " | " | " | " |
| Development of power to assemble data logically | 5 | " | 11 | " | " | " | " | " |
| Increased interest in preventive measures | 5 | " | 11 | " | " | " | " | " |
| Increased students' interest in working out program of nursing care | 4 | " | 9 | " | " | " | " | " |

The difficulties given by these schools in working out this method of instruction were:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Lack of time on the part of head nurses and supervisors | 14, | or | 32 | per | cent | of | the | schools studied |
| Lack of time on the part of students | 12 | " | 27 | " | " | " | " | " |
| Indifference of head nurses and supervisors more interested in practical details of ward management | 6 | " | 14 | " | " | " | " | " |
| Indifference of a certain type of student not interested in the theoretical side of nursing | 3 | " | 7 | " | " | " | " | " |
| Too rapid and irregular rotation of students | 4 | " | 9 | " | " | " | " | " |
| Lack of education of head nurses and supervisors | 3 | " | 7 | " | " | " | " | " |
| Tendency to copy from clinical charts | 2 | " | 5 | " | " | " | " | " |
| Difficulty in getting studies from students on time | 2 | " | 5 | " | " | " | " | " |
| Difficulty in obtaining emphasis on the nursing aspect | 2 | " | 5 | " | " | " | " | " |
| Difficulty in holding conferences with students | 2 | " | 5 | " | " | " | " | " |
| Youth and inexperience of students | 2 | " | 5 | " | " | " | " | " |
| Lack of variety of cases | 2 | " | 5 | " | " | " | " | " |
| Interference of research work on wards by members of the medical staff | 2 | " | 5 | " | " | " | " | " |
| Classes being too large for individual instruction | 1 | " | 2 | " | " | " | " | " |
| Lack of knowledge on part of student in social science | 1 | " | 2 | " | " | " | " | " |
| Inclination on part of student to select dramatic and rare cases for study | 1 | " | 2 | " | " | " | " | " |

It was found from the copies of forms and directions used in some of the schools studied that there is confusion between the experience record and the case study. Experience records are weekly records of a small group of patients, not more than three or four, assigned to the student. These records include a brief social history, medical and laboratory findings, the nurses' observations and the treatment carried out. In the average hospital the greatest difficulty is the maintenance of a teaching staff large enough to allow time for the immediate correction of the weekly records, as much benefit is lost if they are not corrected and returned with suggestions to the student very soon after they have been handed in.

The case study, on the other hand, is an intensive study of a case from

every angle. This implies an understanding of the disease involved, as well as the picture presented by the patient. The student should know the social history, as well as the medical history, that she may understand better his attitude of mind toward his illness and the hospital. This type of work means that an intensive study must be made of all problems involved in caring for the patient over a period of no less than two weeks.

It was brought out by the report that the supervision and grading of these studies present a very definite problem to many schools, and because head nurses and supervisors have no time, it is frequently done by instructors who spend most of their time in the classroom; it would seem that since head nurses have the best opportunity of knowing patients intimately, they are best fitted to help students.

### *The Case Study Method in the School of Nursing at the University of Minnesota*

IN the School of Nursing at the University of Minnesota, students do not keep written experience records of their patients, but case studies are required in every department where the student receives clinical instruction. Before any work was done with the students, the supervisor responsible for developing case studies held classes with the head nurses and floor supervisors. After some discussion, it was found better to have different directions for each department.[2]

At the end of the preparatory period, a course of ten hours on the "technic of building up case studies" is given by the supervisor of clinical instruction in nursing, that students may know the important facts regarding nursing studies, where they may obtain information about patients and how they may organize this information in their studies. Students, through their own studies and through the analyses which go on in conferences and clinics, gather the knowledge thus gained and should be able to sum up the whole nursing problem presented by any patient. Freshmen and Junior students study patients presenting the most fundamental diseases before they attempt the rare and unusual cases. For instance, on medical wards, Freshmen study patients who have diseases of the upper respiratory system, simple cardiac disease, nephritis, obesity, and simple arthritic conditions; and in surgical wards appendectomy, herniotomy and simple fracture cases; older students study the more difficult cases. Generally students do not make intensive studies of patients who have rare and unusual diseases.

The head nurse supervises the selection of cases for study and holds conferences with students whenever necessary. Studies are corrected and graded by the head nurse and staff conferences are held frequently to discuss problems that have arisen in this type of ward instruction. Each quarter the student receives a "Case Study" program card for the record of her case study work. This card contains the student's name and class, with spaces below for the month, ward, and service, diagnosis, grade and signature of head nurse. The student gives this card to the head nurse with the case study, and after recording the grade and signature, it is returned to the student. These cards are brought to the school office at the end of each quarter, and the grades

[2] A full description of the directions for case studies in each of the departments will be found in Jensen's "Students' Handbook for Nursing Case Studies," published by The Macmillan Company.

CASE STUDY PROGRAM Student.....

.....Quarter, 19— Class.....

| Hospital | Ward and Service | Date of Leaving Service | Diagnosis | Grade | Head Nurse |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Approved.....
Supervisor of Clinical Instruction

are placed on the student's permanent record card.

### *Conclusion*

WHILE many difficulties remain in developing this method of instruction in the majority of schools, so much benefit results from it, to both patient and nurse, that it can be warmly recommended. The following suggestions are made to aid schools in developing nursing case studies further than is possible at present.

1. Staff education. It is very necessary that a definite program of staff education be carried out by regular classes, conferences, and clinics. Every encouragement should be given to head nurses and supervisors to take additional courses by attending evening classes or summer school where additional courses in modern methods in education are offered.

2. The head nurse and supervisor be given more time for ward teaching. When the head nurse is attempting to carry out the many duties required in a large ward, without an assistant, it is very difficult for her to have any time left for teaching, even though she may be interested in doing so.

3. A better type of student be admitted to the schools. The fact was brought out by the report of the Grading Committee that

> One-sixth of all the students who have been graduated within the past five years have never gone beyond the first year in high school. This report also states that applicants who have failed to complete high school courses should be viewed with grave suspicion, since there is probably more than an even chance that they are mentally unable to carry work of high school grade, that they are repelled by the orderly and controlled discipline of the educational life, or that they come from families to which professional traditions are unfamiliar.

4. A shorter working day for students. In schools where students are on the wards eight hours, six days a week, in addition to two hours of class work, it is difficult to arouse enthusiasm and interest in such studies unless time is allowed during hours on duty to work at their studies.

5. Library facilities. One of the benefits derived from case studies is the stimulus to read and study nursing problems. Reference books, medical, public health, and nursing journals should be available in addition to textbooks on each subject.

6. Stabilization of rotation. At the University of Minnesota, as well as in

many other leading schools of nursing, an effort has been made to plan the rotation of students so that at least one month will be spent on any ward at one time, and no interruption is allowed in such departments as pediatrics and obstetrics.

As has been seen from the result of this questionnaire, case study has passed the phase of being only an experiment in schools of nursing. Indeed, the student gains so much that it will probably be the preferred method of clinical instruction in schools of nursing in the future, and no accredited school can afford to ignore this development in the education of nurses.

# Correlation of Theory and Practice in Relation to Ward Administration[1]

GLADYS SELLEW, R.N.

QUOTATION from "Nurses, Patients, and Pocketbooks":

Many school administrators will say:

"A good basic training in hospital bedside nursing is sufficient, no matter what field the graduate enters." Evidence that this is not true, in the form in which it is now given, is furnished by the protest now being raised against the results of the present system.

Much of even the "basic course" depends on chance. As was shown in Chapter 16, very few hospitals give their superintendents of nurses a free hand in supplementing student service with graduate service. Almost all hospitals are understaffed. They are trying to carry more work than can possibly be handled adequately by the number of students enrolled; and this has two serious results: The first is, that although the students may be taught good technic of fine bedside nursing, they shortly learn that in times of heavy load they are not really expected to practice those technics in their full exquisite detail. When there are more patients than a student can possibly take care of properly, she learns that it is of no use to report that fact to the office. The superintendent, being helpless as far as assigning additional nurses to the floor is concerned, and not feeling free to criticise the management of the hospital to the student, is obliged to ignore such pleas for help, and the student who insists that she cannot carry the load is quickly made to feel that she has offended.

It does not take a bright student long to realise that what she has been taught is the theory of bedside care, but what she is expected to practice on the wards is always a compromise between theory and necessity. Students of poor moral fibre quickly learn to neglect the less obvious aspects of bedside care and to specialise on the things which show. Students of fine moral fibre may be forced to do the same thing, because they literally cannot give adequate care in the hours allowed, or even in the overtime hours to which many of them are so generally accustomed; but the high-grade student rebels internally against the hypocrisy of a hospital which teaches her how patients should be cared for, which refuses to acknowledge that lower standards may ever be necessary, and which at the same time is not willing to spend the extra money necessary to provide enough workers so that its own patients can be given something approaching the type of care which the school pretends to stand for.

The second educationally pernicious aspect of this perpetual sacrificing of the student to the daily needs of the hospital, is that where work has to be done, and where there are only students to do it, it is frequently necessary to assign a particular student to work in which she has had sufficient experience.[2] Students are kept in the operating room, for example, for weeks and sometimes months longer than need be, not because they are

[1] Read at the annual meeting of the National League of Nursing Education at Atlantic City, N. J., June, 1929.

[2] For detailed testimony on this point, the reader is referred to the "Report of the Committee for the Study of Nursing Education," Dr. C.-E. A. Winslow, chairman, Josephine Goldmark, secretary. The Macmillan Company, New York, 1923.

poorly trained nurses who need more operating room experience, but because they are already so exceedingly skilful that the hospital thinks it cannot afford to let them get away. Similarly, in other departments, it is found over and over again that the assignment of students to certain duties is determined not by the needs of the student but by the needs of the patients in the hospital.

It would be a sad thing indeed were students ever to acquire the attitude of mind which says: "I am more important than the patient. I must not be sacrificed simply because a patient needs me." In other professions students are not ashamed frankly to be seeking their own educational advancement. In nursing such an attitude is unthinkable, and it is to be hoped that the time will never come when student nurses will be more interested in their own welfare than in the welfare of the patients under their charge. To the student the patient should always come first, but to somebody the student ought to come first! Except in those few schools—almost all of them connected with universities—where the education of the nurse is a project separate and distinct from the administration of the hospital, and therefore under separate educational direction with power to act, there is no one in the whole school of nursing to whom the education of the student is of paramount importance. Superintendents of nurses are deeply interested in their schools. They are capable of great sacrifice for their students, but the fact remains that wherever the position of superintendent of nursing service and principal of a school of nursing is held by one person, she must, and probably should, give first attention to the safeguarding of the welfare of the patients in her hospital, and she must over and over again sacrifice the education of the students to that end. Not until schools of nursing are controlled by some person or persons whose chief responsibility is educational and not administrative, can the nursing profession hope to secure graduates with thorough basic nursing education."

This quotation from "Nurses, Patients, and Pocketbooks" is just, and worth serious and detailed consideration. If theory is to influence practice, it must be applied in the practice field. If theory is to influence practice, we must make the conditions on the ward such that the student can carry out the work as it is taught her. We may not be able to immediately solve the difficulty but we may attempt to analyze the situation on the ward, with reference to improving the condition. In my classes in ward administration, I am attempting to bring out the point that it requires time—hours and minutes of nursing work—to give our patients care. We may almost say that the amount of nursing service that we are able to give them depends on the character and number of our nursing body. If we are considering the nursing force in any hospital, a decrease in the amount of nursing service that can be given the patient must mean a decrease in the amount of care that can be given the patient. If we can employ private duty nurses to fill the gaps in our ranks, the nursing care need not be cut and the problem is solved. But if we cannot increase our number in this way, the nursing care which the patient will receive must be cut. Even if the office refuses to recognize the necessity, the nurses on the ward are forced to recognize and meet the difficulty.

The point that I am trying to make is that this problem should not be placed upon the head nurse, general duty, or student nurse. It must be met by the head of the nursing service and the responsibility for the cut in the amount of care given the patients assumed by her. This is the time—not for a head-on collision between theory and practice, in which theory is invariably routed in the student's mind. Such a collision soon makes the student feel that theory has no place in practical work, that theory is something which belongs to the classroom, that it may be followed when everything is in good running order but has no value in helping to bring order out of chaos. If theory has any true value, these are the situations in which it is of especial value; the

confusion lies in the narrow meaning of the student's interpretation of the term theory. She thinks of theory as the ideal method of nursing which has been taught in the classroom. In the rush and hurry of trying to do twice as much as she can possibly do, this ideal method of nursing cannot be achieved. Theory is really something very much broader than her conception of it. To analyze the situation, definitely decide which are the most important and which the least important items of the nursing care, which items must be retained and which must be frankly dropped. Let the student help in this analysis and with the final decision, if possible. After she is graduated and "on her own," she will have to meet many situations of this nature. Let her learn how to meet them; it will probably be one of the most valuable experiences she can have. Let her see how older and more experienced women believe that these experiences should be met.

### *The Element of Time Cannot Be Neglected*

STUDENTS of ward administration must recognize this element of time; how long it takes to do things is something which we cannot neglect. We cannot alter it by staying on duty twelve hours instead of eight. If we work twelve hours a day for any length of time, the quality of the work suffers. It is simply dodging the question. The standard by which to judge good direction of nursing service on the ward from poor direction of nursing care on the wards is: Does the patient receive the maximum benefit from the available nursing service? We must never forget that many intangible factors are comprised in the term "benefit received"—kindness, an atmosphere of peace and quiet, etc. The term "available" must also be interpreted in a spirit of fairness to the student or graduate nurse who carries the work. Let the most experienced members in the nursing body show what good direction of nursing care under the existing circumstances means.

Even in quiet times, when there is no unusual strain, we must be sure that time is allowed for the student to do the work as taught in class. If we cannot achieve the very perfection of nursing, if we cannot give each patient as good nursing care as we desire, let us teach in class what is the ideal and also what we actually intend to put in practice on the wards. There is a steady upward tendency in nursing, but the time will never come when we all, at all times, can equal the very best work done under ideal circumstances.

If the student clearly understands the ideal toward which we strive and frankly distinguishes between the ideal and the methods which we use to meet the exigencies of the situation, she will find no conflict between theory and practice.

Possibly I have misconstrued the statement in the quotation at the beginning of this paper:

> The high-grade student rebels internally against the hypocrisy of a hospital which teaches her how patients should be cared for, which refuses to acknowledge that lower standards may ever be necessary, and which at the same time is not willing to spend the extra money necessary to provide enough workers so that its own patients can be given something approaching the type of care for which the school pretends to stand.

If the hypocrisy lies in the refusal of the hospital to recognize that an inferior type of nursing is necessary, I believe that the statement is absolutely correct. If, however, it implies that an element of hypocrisy exists in

the teaching of a standard of nursing which the hospital is unable to carry out, it does not seem to me that the criticism is just. I do not think that there would be an element of hypocrisy on the part of the hospital in that the institution taught the students an ideal type of nursing, a type which the hospital did not provide for its own patients.

It would seem to me that this condition exists in all professional schools where the practice fields are not artificially constructed for the use of the student, but are fields where actual useful work is carried on by necessity in accordance with scientific laws, economic, sociological, etc.

In all professions (especially those dealing with the most vital needs of life—medicine, nursing, the ministry, teaching, social service, the arts and public utilities), we hope for continual improvement, a continual advance toward a continually receding ideal. If this is true, we train students or workers not only to work under present conditions but also to fit in—to cope with—situations far more ideal than those existing at the time of the students' training.

To reiterate, it seems to me that the rank and file of practice fields could never catch up with the ideal, for the ideal must advance as the work improved.

The hypocrisy, to me, lies in our absolute refusal to recognise that we cannot practice in accordance with the ideal—a mistake which can most justly be attributed to us, but one which should be easy to overcome.

Method of analysis of the care which may be given a patient in a definite amount of time has been given, and would seem to me to be the logical procedure to follow in considering the correlation of theory and practice.

### *A Restatement of a Method of Analysis of the Practice Field Reconsidered from the Point of View of Correlation of Theory and Practice*

THE basis for such an analysis should be a clear statement of the daily routine; stating in some detail the basic care given the patients, and the hours at which the special orders are routinely carried out. Examples of such routine are not hard to find; practically every hospital has some such routine, even if it is not definitely written down.

Such a routine has many functions, but the function that we are considering just now, is its value in the correlation of theory and practice. This picture of the daily routine can be discussed in class; theory will then assume a broader aspect in the student's mind. It could be used as a comparison of the routine care given to patients in various hospitals, and I would suggest that it be used when given to the Senior group as a basis for the computation of the personnel required for different wards. The close relation of the personnel to the budget might also be pointed out. As soon as the student is graduated, she will discover that the ability to put the ideal into practice depends very largely on the size of the budget allowed for the work.

Having found in a general way the items that must be included in the day's work, the next step would be to state definitely how the procedures are to be carried out. The written procedure is necessary to the success of any analysis of the work of a ward. It has several functions, but its value in holding the student to the method taught in class is immeasurable. If new procedures, or changes in existing procedures, are to be made, I would

suggest that the students be permitted to help in the forming of the procedure.

I believe that in many cases the student's reaction to the definite procedure as taught in class is a feeling that she will never find time on the ward to carry it out as taught. The student is quite right in considering the element of time; it is one of the most important factors in correlation of theory and practice. The time studies made by different hospitals, of the actual length of time that it takes to carry out the work as planned by the head of the department, are of great value in influencing the student's attitude. If she does not have time, the fact is clearly shown; if she does have time, the fact can be shown her.

The time slip shows in cold, hard figures just how many hours of nursing service are given on the ward. What is more, it shows just how many hours of nursing service have been given at each hour of the day. We are all familiar with those periods when many of the students are off at class, or the situation on Sunday when everyone has a half-day. Students must go to class and half-days are necessary, but if a comparison of the time slip and the time study show that we are planning to give nursing care, during these periods, which take twice as many minutes to carry out as there are minutes of nursing service accounted for on the time slip, something unexpected and unplanned for is surely going to happen.

What usually happens is that the nurse on the ward decides to omit certain items in the nursing care to be given the patients, or that she succeeds in carrying out all the written orders but slights the basic care; or, what is probably the most common solution of the difficulty, that she accomplishes everything but in a way that should make us blush for our profession. It seems to me that it is far better to definitely decide what procedures in the care of the patients can be omitted, or perhaps what steps in the procedures can be omitted; cutting the work in accordance with a definitely thought-out plan.

Just as it has often been said that our discussion of the work centers about the patient, and the patient is the starting point for the education of the nurse, theory being given in response to the actual problems arising in his care; so I believe that theory, in its larger conception, a conception applied to the whole problem of supplying nursing service for the whole hospital and training of student nurses, must be sought out from all the great field of knowledge ready for our use and applied to the problem. It seems to me that this is one of the reasons for a wider educational background for the nurse. Sociology, economics, (especially statistics), psychology, ethics and logic, all help in the understanding of the relation of the idea to the practical. The present situation must be met and met in such a way that there will be a steady growth toward the ideal. This year of 1929 must be met while we plan for 1930.

The plan, then, for the future, must include a sufficient number of general duty nurses to permit the student to be placed where she will receive the experience that she needs. *We*, not *she*, are responsible for the care of the patient. It has been sometimes thought that the problem may be solved by giving the students the type of training which they need, and insisting that they be given time to carry out the procedures as taught in class, while the general duty nurse is so rushed with work that she is unable

to give the patient the care that he needs. This seems an impossible situation. To repeat a quotation from "Nurses, Patients, and Pocketbooks":

> It would be a sad thing indeed were student nurses ever to acquire that attitude of mind which says, "I am more important than the patient. I must not be sacrificed just because a patient needs me."

When a student sees a general duty nurse unable to give the patient good care, while the patient whom she, herself, nurses receives exquisite care, not because he is in need of greater attention, but because it is considered necessary to her nursing education, she can hardly fail to think that her education is of greater importance than the welfare of the patient. The ideal, then, toward which we work, will be good nursing care for every patient, and a condition in which the student may receive good training—adequate practical training, rich theoretical training—and in which she shall apply her theory in practical work. And while we are working toward this goal, let us not consider any situation so hard or so commonplace that it cannot be improved by the application of theory in practice.

# Suggested Outline of Lectures on Dentistry to Nurses in Training[1]

THIS outline of classes for student nurses in Dental Hygiene is suggested by the Education Committee of the National League of Nursing Education as a supplement to the outline of Nursing in Diseases of the Ear, Nose and Throat in the suggested Curriculum for Schools of Nursing.

ISABEL M. STEWART,
*Chairman, Education Committee.*

*Lecture 1*

INTRODUCTORY LECTURE

*Note.*—This lecture does not call for a detailed discussion. It is only an objective outline to show the relation of Dentistry to the duties of a nurse. It should also endeavor to awaken the interest of the class in the future discussions of the subject of Dentistry.

A. Importance of Teeth
   a. Mastication of foods
   b. Articulation
   c. Expression
   d. Esthetics
B. Mouth Vestibule—voluntary 3 inches of alimentary tract
   a. Mastication—first step in digestive process
   b. Thorough incorporation of ptyalin with starchy foods
   c. Natural teeth compared with artificial substitutes and efficient mastication
   d. Full complement of teeth as compared to teeth missing here and there with effect upon mastication
C. Dental Disease and Systemic Disease
   a. Focal infection
   b. Main paths of infection
   c. Oral manifestations of general disease
D. Oral Cleanliness
   a. Toilet of mouth
   b. Sickroom hygiene
   c. Previous to anesthetic
E. Dentistry and Social Service
   a. Organized state dentistry
   b. Institutions, dental service in hospitals (in and out-patients)
   c. Industrial dental clinics
   d. School dental service
   e. Pre-school dental service—summer round-up

*Lecture 2*

THE TEETH AND SURROUNDING TISSUES

A. Deciduous and Permanent Teeth
   a. Names and number
   b. Comparative characteristics as to shape, size, color, etc.

[1] Prepared by Dr. George H. Wandel, D.D.S., Supervisor, Bureau of Dental Health Education, American Dental Association.

c. Development, calcification, and dates of eruption
d. The six-year molar—location, importance, results due to its neglect

B. Gum Histology
a. Enamel
b. Dentine
c. Cementum
d. Pulp or "nerve"
e. Peri-cemental membrane
f. Gum tissue

*Note.*—Simple slides, charts, and drawings will aid materially in the proper presentation of this lecture.

*Lecture 3*

DENTAL PATHOLOGY

A. Caries or Decay of Teeth.
a. Some theories as to cause
1. Gelatinous plaques and lactic acid associated with bacterial activity and uncleanliness
2. Nutritional, including deficient metabolism of tooth-building minerals due to such factors as lack of minerals in diet, lack of important vitamins, functional disturbance of certain internal secreting glands, etc.
3. Defective formation of enamel—pits and fissures
b. Progressive stages in dental caries (discuss from two standpoints):
1. Progress to formation of fully developed abscess
2. Progress to and including surgical removal of pulp and filling of pulp canal
3. Suggestions as to temporary home treatment of pulpitus and acute abscess conditions

B. Pathological Areas at Ends of Tooth Roots
a. Resulting from degeneration of pulp and resulting putrefaction with pus formation
b. Other possible causes
1. Faulty pulp—canal technic
2. Lack of asepsis
3. Metastatic, or bacterial invasion of site from other sources through blood or lymph stream
c. Discuss types of granuloma
1. Circumscribed or limiting
2. Non-limiting or diffuse

*Note.*—Simple slides, charts, or drawings will be of great value in the presentation of this lecture.

*Lecture 4*

DENTAL PATHOLOGY—*Continued*

A. Periodontoclasia (Pyorrhea)
a. Define
b. Causes
1. Neglect
2. Calculus
3. Injuries—lowering tonus or resistance (poor contacts, cavities, incorrect brushing, etc.)
4. Traumatic occlusion
5. Malpositions of teeth
6. Systemic
7. Nutritional
c. Review progressive stages in development of periodontoclasia
1. Irritation and increased blood flow to site
2. Hyperemia
3. Impairment of function
4. Swelling
5. Pain
6. Bacterial invasion
7. Tissue degeneration—formation of pockets—"pus-pockets"
d. Treatment

B. Vincent's Angina (Trench Mouth)
a. Define, and describe symptoms
b. Cause—means of verification
c. Treatment

*Note.*—Slides, models, and colored drawings would be of great assistance in this lecture.

*Lecture 5*

PREVENTIVE MEASURES AND DENTAL DISEASE

A. Value of Preventive as Compared to Reparative Plan of Dental Care
a. Health and comfort versus disease and suffering
b. Economics

B. Factors in Prevention
a. Developmental influences
1. Pre-natal and post-natal nutrition of mother and child (very important)
2. Health of mother
3. Health of child, absence of childhood diseases
b. Early and regular dental attention
1. Susceptibility and immunity—quality of tooth structure, age
2. Pits and fissures
c. Mastication
1. Foods requiring chewing, soft foods
d. Maintenance of good general health
e. Diet—very important—accepted diet outline
f. Mouth toilet

1. Tooth brush—size, style, care of
2. Dentifrice—powder, paste
3. Technics of brushing teeth—best times to brush
4. Mouth washes
5. Dental floss—use

*Lecture 6*

NURSES' DENTAL RESPONSIBILITIES

A. Private Nursing
   a. Set good example by strict attention to personal mouth hygiene
   b. Contacts with individuals, parents and children
      1. Wonderful opportunities to instruct in dental hygiene, both as to preventive and corrective suggestions
   c. Care of mouth of expectant and nursing mother
      1. Repair of carious areas, and relief of pain
      2. Treatment or removal of areas of infection
      3. Brushing—important periods
      4. Alkaline mouth washes
   d. Care of infant's mouth
      1. What to do and what not to do
      2. Prevent habit formation—thumb sucking, pacifiers, etc.
   e. Care of invalids and convalescents
B. Industrial Nursing
   a. Group and individual instruction important—prevention emphasized
   b. Encourage regular, systematic examination and attention
C. Institutional
   a. Hospital—in and out-patients
      1. Instruction in proper mouth hygiene
      2. Personal demonstration and supervision
      3. Proper standards of oral hygiene as hospital routine
   b. Schools
      1. Instruction and personal demonstration in proper mouth hygiene
      2. Encourage regular dental examination and repair—emphasize prevention
      3. Personal inspection of pupils' mouths
         (1) Decay
         (2) Abscesses
         (3) Gum irritation—Vincent's Angina
D. General Summary and Conclusion

## *Nursing Education in Virginia*

NURSING education at the Medical College of Virginia is organized on a collegiate basis, students being matriculates in the college. The school of nursing is an integral part of the institution like the schools of medicine, dentistry, and pharmacy. Young women who are matriculated in this school share in the general student activities and in the educational facilities of the college. This tends to put nursing education on a truly educational basis, removing it from the older apprenticeship basis.

To be associated with the other professional groups of medicine, dentistry, and pharmacy, who are in training to serve the health of state and nation, is a privilege. This is made possible at the Medical College of Virginia through the close coördination of the four schools of the institution.

Practical nursing education is secured through the college hospitals which include Memorial Hospital, with 160 beds, for white persons over ten years of age; Dooley Hospital, with 60 cribs for children under ten years of age; the Crippled Children's Hospital, with a bed capacity of 50; the St. Philip Hospital, with 176 beds for colored patients and the out-patient department, or health service for the walking sick, with an attendance of 100 patients daily. The unit for crippled children is an incorporated hospital, opened in the spring of 1923, and is a model of completeness for the specific type of work done there. To it the students are assigned for a period of two months during the Freshman or Junior years. It should be pointed out that the nursing in St. Philip Hospital is done by the colored students matriculated in the training school of this hospital. To this training school, organized as a separate unit, qualified colored girls are admitted on the completion of two years of high school work.—Bulletin, Medical College of Virginia, May, 1923.

# Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

### *Teacher Training Courses*

FOUR colleges in different sections of the country are offering summer courses to Red Cross nurses who wish to prepare for teaching the Red Cross Course in Home Hygiene and Care of the Sick. These are offered from July 1 to August 10 at the Pennsylvania State College, State College, Pa.; State Teachers College at Buffalo, N. Y.; the University of California at Berkeley, Calif.; and at the Colorado Agricultural College at Fort Collins, Colo.

The widespread interest in this very practical and useful course of the American Red Cross, especially its inclusion in many schools as a required subject, has created a need for qualified Red Cross nurse teachers. Many chapter nurses, as well as field representatives, taking advantage of these special courses have found them most helpful in their particular fields of endeavor. Little did the Red Cross appreciate, when instruction in this subject was started in 1914, that over 1,500 Red Cross nurse instructors would be authorized in a single year to teach the course. Faith in the usefulness of this type of home teaching was shared by Miss McIsaac and Miss Dolan, who collaborated in preparing the first textbook; their belief in the venture has certainly been fully vindicated.

### *Advisory Committee on Nursing of the Veterans' Bureau*

THAT the Veterans' Bureau, that great post-war machine developed for the purpose of adjusting compensation claims of ex-service men and women and attending to their physical needs, spending as it does well over one million dollars per day on this program, is desirous that the very best medical and nursing advice shall be available, is manifested through its Medical Council with a Sub-committee on Nursing. The names of the greatest men in the medical world appear on the list of those who serve. Dr. Ray Lyman Wilbur, now Secretary of the Interior, has served as chairman for several years, resigning from this office at the last meeting on May 10, but still remaining a member. He was succeeded by Dr. Llewellys Barker, a distinguished psychiatrist for many years associated with the Johns Hopkins Hospital. The Committee on Nursing includes the names of: Adda Eldredge, Laura Logan, Mary Gardner, Elizabeth Fox, Harriet Bailey and Alice Stewart, all experts in their particular field, while Julia C. Stimson, Beatrice Bowman and Lucy Minnigerode have the additional advantage of governmental experience. The National Director of the American Red Cross Nursing Service is chairman of the Committee.

At the last meeting, May 10 and 11, three members only of the Advisory Committee on Nursing were asked to be present—Harriet Bailey, Laura R. Logan and the chairman. Questions relating to ratio of nurse to patient, preparation of attendants and courses of instruction for better preparation in psychiatric nursing for staff work, postgraduate courses for preparation

of teachers, required to carry on the program of staff instruction, were reviewed resulting in the following recommendations to the Medical Council:

The Advisory Committee on Nursing of the Veterans' Bureau in considering the question of ratio of nurses to patients in neuropsychiatric hospitals of the Veterans' Bureau would like to direct the attention of the Medical Council to the fact that graduate nurses are frequently used to perform duties that might well be delegated to less highly trained persons, provided such persons could be given systematic preparation that would qualify them to assume these duties.

The Committee on Nursing, therefore, recommends that a formal course of instruction be given to attendants to better prepare them to render more intelligent and acceptable service to this class of patients. In further consideration of the question of ratio of nurses to patients in these hospitals, the Committee having been informed—because of an inadequate supply of nurses with a basic training in psychiatric nursing that many have been accepted who have not had this special preparation—therefore recommends that routine programs of staff education in psychiatric nursing be initiated in all the neuropsychiatric hospitals of the Veterans' Bureau. Inasmuch as qualified nurse instructors will be required in every neuropsychiatric hospital where staff education of this nature may be initiated, the Committee also recommends that special postgraduate courses for the preparation of such instructors be made available.

The Committee also believes that if these recommendations are adopted and put into practical operation, a more efficient nursing service will be assured which will ultimately result in a material reduction in the established ratio of nurses to patients.

Dr. Wilbur, in his opening address, spoke of the necessity for rearranging ideas on medical practice and the danger of becoming static, advice equally applicable to nurses and nursing. We are reminded here of one of the early leaders in nursing who once said that each day she prayed for an "understanding mind and heart," a prayer that might well be emulated today by others.

General Hines showed some interesting graphs showing the upward trend in hospitalization, especially acute in the neuropsychiatric institutions, stating that it had been estimated that the peak will not be reached until 1947.

Dr. Crossman, the Medical Director, in his usual humorous manner, spoke of the need for younger and more physicians—fifty additional having been allowed.

It is always interesting, at any time, to be received by the President of the United States, but particularly so when the President has but recently taken office. The Council went in a body to visit Mr. Hoover; each was presented by General Hines. The President was most gracious, shaking hands with each, and in a charming speech referred to his high regard for the Council as indicated by his selection therefrom of a member of his Cabinet. We do not know how the medical members felt, but we did not notice any particular evidences of expectancy on the part of the nurse members, lest they be suddenly wrenched from their particular jobs to grace a Cabinet position.

### *Red Cross Nurses in First Aid Stations*

AT large gatherings of all kinds, such as conventions, parades, county fairs, exhibits, a Red Cross first aid station is indicated. Under chapter auspices Red Cross nurses should always be in attendance. Boy and Girl Scouts and other types of volunteers can be utilized, but they should never be asked to perform services where preparation and skill in nursing are required, even though a physician may be in charge. Perhaps no occasion of this nature is more popular than Inauguration Day in Washington. Twenty-five Red Cross nurses

were provided for duty from 9 a. m. until 6 p. m. They covered five first aid tents and eleven ambulances, stationed at various points along Pennsylvania Avenue and the Capitol grounds. Two had the privilege of serving a first aid station at the inaugural ball. Recently nine served in first aid stations in connection with the marathon races. These illustrations serve to indicate the type of place and occasion where such service may be rendered. It should be borne in mind that as unenrolled nurses are not privileged to wear the uniform and insignia of the Red Cross Nursing Service, chapters should be exceedingly careful to secure Red Cross nurses through the nearest local committee on Red Cross Nursing Service. As all chapters have been supplied with the addresses of the chairman and secretary of the nearest committee, there should be no difficulty in securing an adequate staff.

### *Enrollments Annulled*

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Mrs. C. H. Anderson, *née* Lena Ellen Wiley; Lelia Helen Ashley; Eugenia D. Ayers; Mrs. L. W. Baker, *née* Willie Arthur Greene; Mrs. Inez Burkholder; Bernice Gladys Comer; Mrs. George L. Cristy, *née* Ruth Sydia Taylor; Mrs. H. S. Davis, *née* Elsie Patterson Foster; Mrs. J. F. Hooker, *née* Grace White; Mrs. John S. Horton, *née* Katye McCollum; Mrs. Ruth May Knox, *née* Waterson; Mrs. Grace E. Lochman, *née* Hill; Mrs. Edward O. McCroskey, *née* Margaret Graham Brightbill; Mrs. Clifford H. Matson, *née* Frances Cameron Steele; Mrs. George W. Norcutt, *née* Anne Elizabeth Stiles; Mrs. Martha M. Shackleton; Alice Shaw; Agnes Sarah Smith; Katherine Sarah Ward; Mrs. Lutie Parmelia Weaver and Yvonne Webb.

### *Should the Superintendent Interview Nurses When the Directress Is Not Present?*

THIS question was asked by a directress of nurses who was annoyed and humiliated when the superintendent of the hospital requested pupil and graduate nurses to come to his office in order that he might interview them regarding certain matters concerning their work in the wards. The directress of nurses was rarely present.

Such a happening would seem almost unbelievable were it not so common in certain hospitals in this country. The superintendent mentioned forgot a fundamental rule of administration. He neglected to observe the basic rule that lines of authority must be rigidly maintained and that while he has the power to send for a nurse he does not have the right to do so. To carry on the work of any organization, whether it be a hospital or an industrial concern, without adhering to routine administrative principles is to court friction and inefficiency.

In the instances cited, the dignity and the authority of the directress of nurses could not be maintained in the presence of such a practise. If the administrator had desired to question a nurse concerning her work and he felt that the superintendent of nurses was not capable of securing the information for him, he should have requested her to bring to his office the nurse in question. Should a reprimand appear necessary as a result of this interview, it should come from the directress of nurses and not from the superintendent of the hospital.

It would be a fine thing, indeed, if a blue print of organization could be hung on the wall of every hospital and, finer still, if the superintendent, directress of nurses and all other heads of departments would rigidly adhere to the routine paths of routing personal and official orders as indicated in this document.

This applies not only to the superintendent and to the directress of nurses, but to the members of the board of trustees who sometimes in their zeal to improve the work of the hospital forget to hold high the hands of departmental heads whom they have engaged and whom they should support.

"Your Everyday Problems," The *Modern Hospital*, June, 1929.

# Student Nurses' Page

## Dispensary Report

*Verna Zoe Knipple, University of Minnesota School of Nursing, Minneapolis, Minn.*

EVERY morning for four weeks I have hurried over to the dispensary at ten minutes to nine—the hospital time has been ten minutes slow—and I have been hurrying since seven o'clock. A dispensary nurse is in a rather peculiar position on the floor; in the morning she serves diets, "does up" two or three or four patients; on Sunday she takes the load of relief hours from the freshman; she cannot ever feel quite familiar with the patients and the Station. I was always glad that I had to hurry to the dispensary at nine.

Morning circle became, from a rather self-conscious half-hour of informal discussion, an understanding and sympathetic group wherein questions were answered and asked, opinions were offered, and interesting and unusual patients were discussed. I think it was almost the first morning that I was there that the case of Mrs. Molumby and the five little Molumbys—or was it seven?—was told to us by one of the students, how all of them needed tonsillectomies and the county could not assume the responsibility of all of them, how the mother was afraid that she could not possibly pay the $10 fee for each of them, but would do the best she could. A newspaper would probably feature that successfully as a "human interest" story, I thought at the time. There were more like it every week—a woman who needed an operation, but who did not dare to leave her husband because he was a diabetic and dependent on her for the weighing and calculating of his diet; a worried young father who brought a most mumpy-looking little boy into Pediatrics and wanted a diagnosis, in spite of the fact that he had a little daughter sick in bed at home with the mumps; an exasperated mother who thought her little boy was "playing sick" when he came into the clinic with a temperature of 103.4° and a palpable axillary abscess.

I was glad to know that there was such an organization as Social Service to care about social conditions, to do follow-up work on carcinoma cases, and to help some of the poor, bewildered sick people. The nurse and doctor, while they can understand and give kindly advice, perform treatments, answer questions, reassure, and be sincerely sorry and concerned, can be no longer than the dispensary and can go no farther, in the majority of cases.

Pediatrics offered the widest variety of diseases of any of the clinics in which I worked. There was always something new or unexpected, usually children who were unquestionably ill or abnormal; I only saw one case of malingering. I remember, in particular, a young mother who brought her

baby to the clinic for a physical when it was a month old, and who had not dared to remove its adhesive name tag. She looked unutterably relieved when the nurse laughed and took it off. Children were brought in by anxious mothers with everything from flat feet to mosquito bites—from diabetes to scabies. I often found myself wondering how mothers could dare to bring children into the world and rear them with so much complacency when so many things could and probably would happen to them. Pediatrics, then, left me acutely conscious of how very much children in this world need care and attention and treatment, a healthy parentage, and a good physical start.

Gynecology and Obstetrics were especially interesting. In Gynecology one came in contact very often with the morals of women—often the extremes—routine gonorrhea cases that came every other day, that had been coming for months, probably, and would likely come for months ahead. I learned here, more than in any other place, I think, a heterogeneous quantity of facts which must be accepted by a nurse, sooner or later, if she is going to be able to understand and help and not merely judge. Everywhere in the dispensary I have noticed, but mostly here, the frankness between doctor and patient. That the clinics serve also as a method of teaching medical students is partly responsible for it, that the patient must keep interested and concerned with his own condition, so that he continues his visits and treatments, also enters in. I shall never forget how splendidly a woman was able to endure being told by the doctor that she had carcinoma of the cervix and that it was inoperable.

My longest service in dispensary was in Obstetrics. I had enjoyed Obstetrics most, of my hospital services, and had so wanted some understanding and practical experience in prenatal work. The physical examination, given routinely, is such a sensible procedure, and the patients are entirely coöperative and anxious to come. There was only one toxic case that came in while I was there, a gravida xiv with a three plus albumin, severe headache, rising blood pressure and edema. She was taken to the hospital, labor was induced, and both she and the baby came through splendidly. When patients come in, day after day, normal in every respect, and delivering normally, a case such as this keeps the need of prenatal work apparent. Obstetrics presented a variety of social problems—the mother physically unable to bear any more children, the mother financially unable, the mother not wanting to be pregnant, and the unmarried mother. The willingness of the University Hospital to take the unmarried mother and the kindness and impersonalness of everyone does much, I know, to help a situation that might be so very difficult. I had never come in contact with an unmarried mother before, and I was glad to know that even so, the baby came first with her.

I would have liked to have been in the Dermatology clinic longer. It was primarily luetic, though there were other skin conditions frequently. Here the familiar words "chancre," "mucous patches," "roseola," "gumma," came to mean conditions which I actually saw—I had never seen any of them before, outside of a textbook. I came to divide the people coming in for treatment as those who were infected innocently or otherwise, but who have a practical view of the disease, are not ashamed of it and want, very earnestly, to be cured; those who come for treatment merely to ward

off disagreeable symptoms and who will probably become reinfected; those who are crushed and broken by the shame of such a disease; mothers who are being treated for the sake of the children; little children who cannot understand what it is all about and who try not to be afraid of the long needles.

In Surgery, I had a very clear conception of what is typical of a small town doctor's usual day in his office. Why this should be more so in Surgery than in other clinics I cannot quite say. Surgery was always busy, there were patients and patients, doctors here and there, swarms of clerks, dressings to be done, broken bones, boils to incise, veins to be injected, and ever so many little things—warts, ingrown toenails, cysts—and sometimes even tumors of quite a respectable size were removed in the little operating room. The results in Surgery were very gratifying to watch; there was always some treatment performed, and when the patient came back the next time he was definitely either better or worse. The injection of varicose veins was new to me, and the improvement of the veins under treatment was very evident from week to week. During my service, there were four or five patients who had come in with marked varicosities who were discharged from the service as cured.

I did not want to leave the dispensary; I wish the service there could be extended in some way. The dispensary service, as others have told me and as I will tell others, is different than anything else in training. There is routine there, and yet not an apparent and rigid routine. Patients are people; they are not brought to a common plane by hospital gowns and grey bathrobes, and they act differently than they would if they were institutionalized.

I cannot classify the outpatients as belonging to any particular social or racial or mental strata. There were many with foreign names and manners, but just as many with ordinary American names and ways. Some were ill, most all of them, but here as always there were those who were probably neurasthenic—some were very poor, some with average incomes. Those who were educated or well dressed were the exception and easily picked out in the crowds. Often women came in, very well dressed and prosperous-looking, and one was inclined to wonder about it. That the dispensary is for the sick, and not only for the sick poor, is a debatable question. Yet the long lines of waiting people, the slow moving machine of the clinics, the delays of the involved registration, protect the dispensary through the individual himself, in some measure.

When I think of how the registration numbers of the patients are up in the seventy thousands, it seems almost unbelievable that so many people could have gone through the dispensary clinics.

And when it follows that the majority of these people would either not have been able to obtain medical assistance if it were not for such an institution as the dispensary, or would have obtained it through an ill-afforded sacrifice, the position of the dispensary seems to be plainly an economic necessity and security.

# The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

## The Anonymous Letter

THE New Jersey State Board of Examiners of Nurses, collectively, and the members, individually, have at various times received anonymous letters bringing complaints against certain unnamed individuals and against various institutions throughout the state. We believe it is the policy of most people to ignore anonymous communications, the fact that they are anonymous proclaiming the cowardice of the writer in failing to sign a letter if he or she has legitimate cause for complaint. However, we feel that it would be well to make plain that we are subject to certain laws and that the powers of this Board are therefore limited, and we know of no better method of apprising the nursing public of such facts than through the medium of the *Journal*. Perhaps in this way we may reach those individuals whose inquiries have taken the form of anonymous letters, yet who claim they are registered nurses, a fact which seems hard to believe, as we feel it quite unnecessary for a registered nurse to resort to such methods to obtain any help which may conscientiously or legitimately be given by this Board.

We should like to state, first of all, that we are governed by certain laws known as the Nurse Practice Act; that our jurisdiction begins and ends with the registered nurse, and that we shall be glad to send a copy of the abstract of this act, which is now in use, to anyone who will apply for it. We have no control over the commercial registries; therefore, we cannot dictate to them whom they shall and shall not register, but we do have a certain amount of control over the registered nurse, as it is through this Board she must obtain her registration. We have no control over the private or general hospitals whose graduates do not apply for registration, but we can exert a certain amount of control over the training schools of hospitals, inspected by us, whose graduates are eligible for registration by this Board. There are certain standards to which they must conform if they are placed upon the approved list and if complaints are made, they are investigated by the Educational Adviser appointed by this Board, and, unless the officers of such hospitals are willing to cooperate with us, the school may be taken off the approved list and their graduates not permitted to come up for examination for registration.

The question of foreign graduates has also been a cause of complaint. These graduates are not registered in this state unless they can meet certain qualifications, which are on the same plane as those required of our own graduates. Of course, few can do this; therefore, few can register in New Jersey.

For the control of hospitals throughout the state, we have the Department of Institutions and Agencies and this department, I am sure, would investigate any condition arising in hospitals which might be detrimental to the patients served.

There are many avenues open to those who would seek redress or make complaints, such as the Alumnae Associations, Boards of Directors of hospitals, Central Registries if any, the New Jersey State Nurses' Association Headquarters, physicians employing unqualified nurses, etc.

We feel that the graduate nurses of this state, registered and in good standing in their communities, have a much better chance to educate the public and prevent the unqualified nurse from practising in fields for which she is not equipped than has this Board. It should be made clear that, without question, there is a field for the undergraduate, the practical nurse and the attendant, and no one would be disposed to interfere with them if they practice as such. However, the State Board of Examiners of Nurses may take up the matter of any person posing as a registered nurse or using the title of R.N., unless she is a qualified nurse and registered in this state. We also are able to handle matters wherein any registered nurse of this state is disqualified for any moral or physical reason which is detrimental to the profession of nursing, or if from another state, such matters will be taken up directly with the nurse and the State Board of Examiners under which she qualified.

The State Board of Examiners of Nurses will welcome all inquiries and hear any complaints which are legitimate, assuring those

making such complaints that they will be directed to the proper sources for redress if we are not able to take care of them, but we wish to ask that any such letters or inquiries be signed or complaints made in person, for the protection of yourselves as well as the Board. It must be remembered that the matters taken up by this Board must necessarily be substantiated, and anyone unwilling to openly voice her complaint can hardly expect the members of this Board to act upon her suggestions.

The nursing law as it now stands does not forbid the nurse from practising who is not registered, but does forbid the use of the R.N. or claims to registration. The employment of non-registered nurses is pretty well taken care of, so far as institutional work is concerned, as all approved hospitals refuse to employ nurses who are not registered, in executive positions. Therefore, the only avenue left for them in the hospitals is general duty or in other departments where the instruction of students does not enter in. Thus the activities of the unqualified nurses are very well controlled, so far as Class A hospitals are concerned, but with the public, the practitioner, the commercial registries and the hospitals run on a profit basis, only, we have no control. Therefore, education and legislation seem to be the only way out, and certainly a small group of five women, composing the State Board of Examiners of Nurses, can hardly be expected to set the whole nursing profession straight and keep everyone in the class to which she belongs.

Any information concerning the Nurse Practice Act will be cheerfully given if such inquiries are sent to the New Jersey State Board of Examiners of Nurses, 42 Bleecker Street, Newark, N. J.

James E. Ware,
*President of the Board.*

## *Nursing Conditions in Peru*

I AM returning after three years spent in the British American Hospital of Bellavista, a suburb of Lima, Peru. During that time, I have seen considerable progress in our training school for nurses in connection with this institution; one of the important steps being the securing of national recognition, with the receipt of the second national training school certificate issued by the Peruvian government. The graduate nurses of Peru have recently organized themselves into a society for the promotion of nursing education in Peru; the minimum requirement being three years as student nurse, and two years' practice after graduation before admission. It may seem rather stiff to us, but under the circumstances it is just as well, for then far the "caste system," has not permitted any of its better class young women to enter a profession which incorporates anything as menial as physical work, so the training schools have been able to require only graduation from grammar school as the minimum educational requirement. You will agree that this is rather little to build on, and it means that much more work must be included in the three years' curriculum than we would think necessary at home. Another accomplishment has been the establishment of a registry for nurses for private duty, and with this has had to go the creation of a demand for the private duty nurse. Our own institution could not absorb all its own graduates, when they began to number more than a dozen each year, but we are beginning to place them in various kinds of work.

Ruth E. Earle.

*California.*

Condensed from a letter in the *Bellevue Alumnae Bulletin.*

## *A Request*

CAN anyone give me information about a device for holding a book or magazine for an invalid not strong enough to hold them for himself?

E. J. L. C.

*807 West 113th St.*
*New York*

## *Journals on Hand and Wanted*

MRS. E. C. DAYTON, Clifton Springs, N. Y., wishes to secure copies of the *Journal* as follows: Volume 1, complete; Vol. 2, No. 2; Vol. 3, No. 2, 5, 6. Mrs. Dayton has on hand many copies from October, 1900, to November, 1922, which she will sell or exchange.

## *Out of the Mail Bag*

AM enclosing a renewal on my Journal. Am enjoying every copy and find a great many interesting, as well as educational and inspiring articles which make me want to press on and learn more to help the suffering in the world. Doing private duty in a rural community, many things come up that are puzzling."

# Abstracts

Robert E. Barney, M.D.: Ringworm of the Feet. (Bulletin of Academy of Medicine, Cleveland, May, 1929.)

With the advent of warm weather and the return to golf, swimming and tennis, it seems timely to call attention to the common and at times troublesome ringworm infection of the feet.

Clinically, the eruption presents itself in different forms. It may occur between the toes as a maceration of the epidermis with associated weeping, the process extending to the base of the toes both on the dorsal and plantar aspects where there is definite margination with more or less inflammatory vesiculation and pustulation. Involving the plantar surface it may occur as acutely or subacutely inflammatory vesicles and pustules varying in size from pinhead to small pea. These lesions are arranged in variously sized annular patches with central involution and peripheral extension. In some instances there may be a marked associated scaling.

Subjectively there is usually marked itching with various degrees of pain. Occasionally in the more severe cases there is an associated lymphangitis and painful involvement of the inguinal lymph nodes.

The contagiousness of the process is illustrated by the fact that many cases are found among members of golf and tennis clubs, swimming pools and gymnasiums, who use the same dressing rooms and shower baths. It is a common clinical observation to find the eruption existing in two or three members of the same family. In this instance the bath mat may well be one of the means of transfer.

In dressing rooms and shower baths, where favorable circumstances for the transmission of the organism exist, prophylaxis may be practiced by bathing the feet in antiseptic solution. In addition, it would be advisable if possible to deny individuals with the infection the use of such places until the condition has involuted.

P. Lundy: Treatment for Electric Shock. (The Canadian Nurse, May, 1929.)

Electric accidents from a medical and nursing standpoint may be subdivided as follows:

(1) Electric shock.
(2) Electric burn.
(3) Associated traumatic conditions such as wounds, fractures and other types of injuries.
(4) Complications of electrical injury such as paralysis, organic and functional.
(5) Sequelae of electric injuries; scars, deformities, psychosis, neurosis, neurasthenia and melancholia.
(6) Death.

Electrical accident is caused by the individual coming in direct or indirect contact with a conductor of electricity. The shock may be accompanied with unconsciousness of varying duration, or death may result.

Effects or conditions are: rigidity of muscles, more or less generalised; interference with or paralysis of respiratory system; excitation of central nervous system; spasms of blood vessels with congestion and edema.

The exact mechanism of death from electrical shock is uncertain, but at present it is thought that death may be due to either a paralysis of the respiratory or vasomotor centres, or to ventricular fibrillation.

From the nursing standpoint we are not so much interested in the cause of death as the effects of the remedial measures to help prevent death. This means action and that must be immediate. Quickly release the victim from the current, being careful to avoid receiving a shock. Use any dry non-conductor (rubber gloves, clothing, wood, rope, etc.) to remove either the victim or the conductor. Beware of using metal or any moist material, endeavor to free one hand at a time; if necessary, shut off the current. If the victim is on a pole, see that it is secure, to avoid further injury by falling. On the individual being removed from the contact with the current, artificial respiration is at once instituted, the Schaefer or Prone Pressure method being used:

Place the patient face downward, one elbow flexed, forehead resting on wrist, face turned opposite flexed elbow. Loosen neck and wrist bands and clear air passages, if jaws are relaxed. Straddle the patient, kneel with the knees just below the hip prockets, place the palms of the hands on the small of the back

with the fingers resting on the ribs. With arms held straight, swing forward slowly so that the weight of your body is brought to bear on the subject. Two or three seconds is the time this should take. No violence should be used as internal organs may be injured. If another person is present he can clear the air passages, loosen neck and waist bands, but no delay must be made in commencing artificial respiration.

When notification is received that a patient suffering from electric shock is on his way to the hospital, a large airy room, if possible with two windows, is prepared at once.

Place the bed near a window. Arrange a fracture board (not in the usual way for a fracture) but across the centre of the bed. This serves a twofold purpose: First, as a sufficient support for the victim's abdomen and chest; and second, an easy method for workers who, without one intermittent stroke, continue their work faithfully and skilfully until rigor mortis has been pronounced, or the patient shows signs of restoration. Protect the mattress and make the lower part of the bed as for an ether bed, but do not put any top clothing in place. On a radiator or back of a chair have old blankets folded.

On the bedside table have two emesis basins, ether wipes, gauze, sponges, cotton swabs, mouth gag, tongue forceps, needle holder, curved needle with strong silk and a strip of adhesive.

Stimulants-Caffeine, Soda-Benzoate Ampule, and a hypodermic is prepared with the same unless otherwise ordered.

Eight hot water bottles at correct temperature are filled, covered and placed between the blankets.

The oxygen tank is in readiness to turn on, and be sure there is an adequate supply on hand.

On the arrival of the ambulance the patient is placed on the bed face down, resting on flexed forearm, face turned away from bend in elbow, with as little interference with the artificial respiration as possible. Cover the upper and lower part of the body with blankets placed crosswise. Hot water bottles are to be immediately placed to axillae, chest, limbs and feet.

Remember, no attempt must be made to undress the patient.

Oxygen must be given continuously. Authorities say pulmotors are contra-indicated and some say stimulation is of no avail. However, observations do not lead us to believe it to be injurious.

Do not interfere in any way with those who are giving artificial respiration. The nurse's duty is to keep the mouth and throat free from mucus and continue oxygen, the doctor may secure the tongue with a suture if necessary.

See that hot water bottles are replenished by replacing one when one is removed, and the hypodermic always in readiness to administer.

Do not become weary in well doing until the doctor has pronounced rigor mortis present.

Our first case, May, 1927, had artificial respiration administered continuously for eight hours, and made a good recovery. In the second case, after three hours' work rigor mortis was present; while in a third case, artificial respiration was continued for five hours and the patient fully recovered.

Burns are treated after respiration has been fully established by the order of the physician. The patient may then be undressed, bathed and general care given. Convalescence depends on the systemic effect of the shock, and will be treated accordingly by the physician.

Joshua Rosett, M.D.: The Epileptic Seizure, Its Relation to Normal Thought and Normal Action. (Archives of Neurology and Psychiatry, April, 1928.)

There is a strong probability that all neuro-heredity statistics, including those of epilepsy, are in a way misleading. It is impossible to prove an inheritance of a defective nervous system as such. Generation after generation may be in possession of a defect consisting not only of a disproportion between the child's head and the mother's pelvis and pelvic organs, but of a defective correspondence between the special metabolism of pregnancy and the embryonic formation of the enormously complicated structure of the human brain. Even when epilepsy is apparently inherited from the father, it is unsafe to conclude that there is an inheritance of a defective brain rather than an inheritance consisting of a metabolic defect which by its action on the brain is the cause of epilepsy in both father and child.

That the arts of obstetrics and gynecology are adequate to save a number of lives of both mothers and infants, and even to reduce the percentage of intracranial damage, is an established fact. But no rational person can doubt that these recently arrived arts must perpetuate defects by enabling defectives to survive and procreate. Whether the progress of the medical arts will entertain and compensate for the increasing numbers of defectives in successive generations, or whether a point will be reached when the medical arts will be swamped by the number of defectives, only the future can show.

# News

Notes.—News items should be typed, if possible, double spaced, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

## The American Nurses' Association

A. N. A. Headquarters

Headquarters of the American Nurses' Association has grown rapidly in personnel during the past few years, but until recently the Headquarters' office had not expanded proportionately.

The result was an unavoidable crowding, and hence it was with real satisfaction that arrangements were completed in late May with the National Health Council to obtain space immediately adjoining the office of the A. N. A. at 370 Seventh Avenue, New York City, thus enabling the office to be expanded without the difficulty of moving.

In early June the enlarged offices, freshly painted and rearranged, were occupied. Besides correcting the crowded condition, this added space gives sunlight for the office staff which had been working entirely by artificial light, and it makes possible a desirable cross ventilation. There are three windows in the new offices, separated by partitions. In the largest of the sections thus made, are the office manager, bookkeeper, secretaries, and file clerk. The middle section is used by the field secretaries and the publicity secretary, and the third is that of the director. These three rooms open into the main entrance portion of the office which is used for the files and as a reception room.

The change in the office does not alter the strategic position which the A. N. A. has occupied, next to the library of the National Health Council; rather it improves the situation of the office, the door of which, now, is directly in front of the elevators.

A. N. A. Headquarters is your headquarters. Come to see it when you are in New York. Meet the staff which is ready on all occasions to do what it can for you, and if you have problems connected with your work, talk them over, or write to Headquarters about them; it may help.

### The Registry Study

Julia P. Wilkinson, Field Secretary of the American Nurses' Association, has left on her mid-western trip to make a study of the official registries of Detroit, Chicago, Milwaukee, Minneapolis and, possibly, Des Moines.

This trip is a step in the program planned in the conducting of this study of registries. In outlining the work, the emphasis borne in mind constantly has been that the study is only to find facts. No analysis with a view to a critical survey of any registry will be made by Miss Wilkinson during her present study.

The first step taken in seeking information about the registry situation was the assembling of all available material which gave information about the registries. A questionnaire then was prepared and was accepted by the Registry Committee, after which its effectiveness as a fact-finding device was tried in several places. Visits then were paid to registries in New York, New Jersey, Providence, New Haven, and Boston.

No plans for further field work will be made until Miss Wilkinson returns from her present trip. As, at the present time, no two registries, it appears, are alike in their systems and methods, it will be determined where next to seek information only after the results of the present field work have been analyzed.

When the field study has been completed and recorded, the second main step in the study will be undertaken: namely, the developing of points and policies that are common to all registries. In the main the questions to be answered will be: What are the essentials in good registry organization,

in good registry operation, in good registry programs, in good registry ambitions? What working methods are found most successful in reports, record forms, bookkeeping methods, methods of evaluating work through statistical reports?

The report which them will be made will be based on the answers found to these and similar questions. The next steps in the survey will depend upon the work already done. Based on the facts found in the study, it is hoped to define definite policies relative to the developing of minimum standards, working methods, and other details of registry work which, it is hoped, will serve to guide registries throughout the country.

It would appear that the study of registries is not a single project but a continuous responsibility. Registries now are in an evolutionary stage. If new developments are to be followed and studied, and if it is to be possible to keep abreast of this rapidly growing work in nursing, it seems evident that the study of registries cannot be confined to a single study but must continue as the work in the registries continues. Only through this means, it would seem, can the ultimate objective be realized of adapting and shaping the work of the registries to fit into the health scheme of their communities in order to bring to the communities adequate nursing care.

### Headquarters' Scrapbook

When you want some facts in a hurry and you know that you have read them somewhere but you cannot remember where, what do you do? Do you dig around in your mind, trying to recollect what it was, specifically, that you read and where you read it? Then, do you rummage through your magazine pile until you find the story or discover that the issue you want has been thrown away?

Such an experience is apt to lead to the keeping of clippings which may prove of future value. Then comes the problem of what to do with the clippings. Numerous forms of files and kindred accessories are available for the storing away of information which may be of service, and an excellent device for the keeping of clippings is the scrapbook.

The scrapbook file as developed by Janet M. Geister, Headquarters' Director, is so successful that she has broadened it for use, not only for herself but for the staff which, in turn, reciprocates, by contributing to the contents of the file.

Mounted in loose-leaf paper-bound folders which are labelled according to subject and placed in the scrapbook file, are clippings from newspapers, magazines, periodicals, and reports on subjects pertaining to nursing or having a bearing on professional problems. The system is simplicity itself. When the clipping is removed, it is placed at once in the proper folder. Every month or so, the collected clippings are reviewed, and those that seem worth saving after that lapse of time are mounted and are placed again in their folder.

The subjects in the scrapbook file now are indicative of the topics in the process of study at Headquarters. The folders include the topics of hourly nursing; of farming, because of its economic problems paralleling those in private duty nursing; organization of nursing service; nursing situations in general; working conditions and methods; allied medical questions, (a) from the medical standpoint, (b) from nursing standpoint; private duty problems; nursing reports; time studies; community nursing and health problems; facts for and in organizing speeches; education and reciprocity; pensions; hospital problems; and the registry scrapbook.

## *Bordeaux School Campaign*

The first gift presented as a memorial to an individual nurse was received for the Bordeaux School Fund during the past month. The nurses of the Mobile (Alabama) Infirmary Association gave $15 to perpetuate the memory of Ollie Rizer, who gave her life in Red Cross service during the World War.

The time set for the completion of the $25,000 fund to build the right wing of the American Nurses' Memorial School at Bordeaux, France, almost is over and there remained, still, when the *Journal* went to press, more than $9,000 to be raised.

In many instances the state associations are not turning in their receipts to Headquarters until the entire amount of their quotas has been reached, but all the states are urged now to delay no longer but to send to A. N. A. Headquarters the gifts of their nurse members, so that the fund can be completed before the meetings of the International Council of Nurses in mid-July.

Contributions from States to June 6, 1920

| State | Quota | Contributions |
|---|---|---|
| Alabama | $222.49 | $222.49 |
| Arizona | 35.00 | 35.00 |
| Arkansas | 169.00 | .... |
| California | 2,112.00 | .... |
| Colorado | 272.00 | 5.00 |

| | | |
|---|---|---|
| Connecticut | 744.00 | .... |
| Delaware | 60.00 | 60.00 |
| District of Columbia | 285.00 | 320.15 |
| Florida | 320.00 | 434.20 |
| Freedmen's Hospital | 26.00 | ..... |
| Georgia | 314.00 | 227.10 |
| Hawaii | 20.00 | 171.75 |
| Idaho | 22.00 | .... |
| Illinois | 1,915.00 | 1,075.10 |
| Indiana | 620.00 | 311.35 |
| Iowa | 682.00 | 355.20 |
| Kansas | 288.00 | 176.22 |
| Kentucky | 228.20 | 2.00 |
| Louisiana | 695.20 | 617.80 |
| Maine | 102.00 | .... |
| Maryland | 921.20 | 794.80 |
| Massachusetts | 1,028.20 | .... |
| Michigan | 1,142.40 | 1,211.60 |
| Minnesota | 994.00 | 662.45 |
| Mississippi | 20.40 | 20.40 |
| Missouri | 967.60 | 1,022.00 |
| Montana | 68.40 | 130.25 |
| Nebraska | 310.00 | 319.24 |
| Nevada | 12.00 | 12.00 |
| New Jersey | 811.20 | 926.25 |
| New Hampshire | 157.60 | 168.10 |
| New Mexico | 20.20 | 20.20 |
| New York | 3,003.00 | 748.80 |
| North Carolina | 310.40 | 322.40 |
| North Dakota | 74.00 | 140.50 |
| Ohio | 1,708.00 | 1.00 |
| Oklahoma | 177.20 | .... |
| Oregon | 288.00 | .... |
| Pennsylvania | 2,020.20 | 25.00 |
| Porto Rico | 11.00 | .... |
| Rhode Island | 202.20 | 261.20 |
| South Carolina | 114.00 | 84.40 |
| South Dakota | 87.20 | 87.20 |
| Tennessee | 222.00 | .... |
| Texas | 775.00 | 926.60 |
| Utah | 70.00 | 70.00 |
| Vermont | 102.40 | .... |
| Virginia | 284.00 | 237.80 |
| Washington | 485.20 | 175.00 |
| West Virginia | 102.00 | 35.10 |
| Wisconsin | 466.40 | 25.00 |
| Wyoming | 16.00 | 16.00 |
| | | $12,926.98 |
| Contributions received outside of state associations | | 2,075.00 |
| Contributions for special purposes | | 550.00 |
| | | $15,551.98 |

## Statement of Income and Expenditures of the American Nurses' Memorial Committee for the Seven Months Ending May 31, 1929

*Income*

| | | |
|---|---|---|
| Contributions | $15,141.03 | |
| Interest on bank balance | 42.16 | |
| | | $15,183.19 |

*Expenditure*

| | | |
|---|---|---|
| Printing, stationery and supplies | $112.25 | |
| Salaries | 65.00 | |
| | | 169.25 |
| Excess of income over expenditures for seven months ending May 31, 1929 | | $14,999.94 |

June, 1929

### Assets and Liabilities

May 31, 1929

*Assets*

| | | |
|---|---|---|
| Cash in Corn Exchange Bank | | $15,299.84 |
| Total assets | | $15,299.84 |

*Liabilities*

| | | |
|---|---|---|
| A. N. A.—Underwriting drive | $300.00 | |
| *Surplus*—Excess of income over expenditures for seven months ending May 31, 1929 | 14,999.84 | |
| | | $15,299.84 |
| Total liabilities and surplus | | $15,299.84 |

## *Nurses' Relief Fund*

### Report for Month Ending May 31, 1929

*Receipts*

| | |
|---|---|
| Interest received on investments | $65.00 |
| Interest received on bank balances | 27.64 |

*Contributions*

| | |
|---|---|
| Arizona: District 4, $1; collected at state meeting, $1.55 | 2.55 |
| California: State Nurses' Assn. | 253.40 |
| Florida: District 13 | 80.00 |
| Illinois: District 1, Michael Reese Hospital Alumnae Assn., $5; District 4, St. Mary's Hospital Alumnae Assn., La Salle, $5 | 55.00 |
| Michigan: State Nurses' Assn., $1,500; contributed by a former beneficiary, $5 | 1,505.00 |
| Minnesota: District 2, St. Luke's Alumnae Assn., Duluth, $20; St. Mary's Alumnae Assn., Duluth, $12; District 3, Deaconess Hospital Alumnae Assn., $5; Ethel Hospital Alumnae Assn., $97; District 5, Hibbard Hospital Alumnae Assn., $20; St. Barnabas Hospital Alumnae Assn., $24; University Hospital Alumnae Assn., $5; individual members, $1; District 4, Anchor Hospital Alumnae Assn., St. Paul, $20; Bethesda Hospital Alumnae Assn., $20; St. Joseph's Hospital Alumnae Assn., $104; St. Paul's Hospital Alumnae Assn., $14; St. John's Hospital Alumnae Assn., Red Wing, $20; Fairbault nurses, $20; Lakeview Hospital Alumnae Assn., Stillwater, $5; individual members, $12.50; District 7, individual members, $9 | 384.50 |
| Missouri: District 2, Kansas City, Independence San. Alumnae Assn., $5; District 3, St. Louis, $9; St. John's Alumnae Assn., $150; District 7, Columbia, University Hospital Alumnae Assn., $6 | 165.00 |
| New Hampshire: State Nurses' Assn., $20; Margaret Pillsbury Alumnae Assn., $5; Mary Hitchcock Alumnae Assn., $10; four individuals, $4 | 39.00 |
| New Jersey: District 1, St. Barnabas Alumnae Assn., $25; individuals, $76; District 2, Barnert Hospital Alumnae Assn., $26 | 127.00 |

New York: District 2, $60; District 7, $120; District 12, Mt. Sinai Hospital Alumnae Assn., $600; individual contribution, $5 ..... 200.00
Pennsylvania: Abington Hospital Alumnae Assn. ..... 10.00
Rhode Island: Butler Hospital Alumnae Assn., Providence, $50; Homeopathic Hospital Alumnae Assn., $50; Women's Hospital Alumnae Assn., $5 ..... 105.00
South Carolina: State Graduate Nurses' Assn. ..... 31.00
Texas: District 2, $7; District 6, $5; District 12, $5; District 14, $24; District 16, $10.50 ..... 51.50
Washington: District 3, Walla Walla, $20.50; District 6, Yakima, $20 ..... 40.50
Wisconsin: District 4 and 5, St. Joseph's Alumnae Assn., $25; St. Mary's Alumnae Assn., $50; 6 individuals, $6 ..... 81.00
$1,555.50

*Disbursements*

Paid to 101 applicants ..... $1,747.60
Salaries ..... 170.83
Postage ..... 20.00
Printing and stationery ..... 13.03
Collection on checks ..... .05
$1,933.60

Excess of income over expenditures for month ending May 31, 1920 ... $374.10

All contributions to the Nurses' Relief Fund should be made payable to the Nurses' Relief Fund and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in each state. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman or the Director of the American Nurses' Association headquarters, 370 Seventh Avenue, New York, N. Y.

## *Isabel Hampton Robb Memorial Fund*

REPORT TO JUNE 12, 1920

Previously acknowledged ..... $94,289.12

*Contributions*

Alabama: District 6 ..... 10.00
Iowa: District 2, $25; District 8, $2.50; Burlington Hospital Alumnae, $5 ..... 17.50
Massachusetts: Middlesex Branch ..... 25.00
New Hampshire: State Association ..... 5.00
Oregon: District 3 ..... 5.00
Pennsylvania: West Side Hospital Alumnae, Scranton ..... 5.00
Total ..... $94,357.62

MARY M. RIDDLE, *Treasurer.*

## *McIsaac Loan Fund*

REPORT TO JUNE 12, 1920

Balance, May 15 ..... $1,234.81
Bank interest ..... 1.04
Interest on loan ..... 4.00

*Contributions*

Iowa: District 2, $25; District 8, $2.50; Burlington Hospital Alumnae, $5 ..... 17.50
Kentucky: Western District ..... 5.00
Massachusetts: Middlesex Branch ..... 25.00
New Hampshire: State Association ..... 5.00
Oregon: Third District ..... 5.00
Pennsylvania: West Side Hospital Alumnae, Scranton ..... 5.00
Total ..... $1,302.35

*Disbursements*

June 3, Three loans of $100 each ..... 300.00
Balance ..... $902.35

MARY M. RIDDLE, *Treasurer.*

## *Army Nurse Corps*

During the month of May, 1920, orders were issued for the transfer of the following named members of the Army Nurse Corps to the stations indicated: To Station Hospital, Fort Benning, Ga., 2nd Lieut. Ethel R. Murbach; to Army and Navy General Hospital, Hot Springs National Park, Ark., 2nd Lieuts. Elizabeth MacKinnon, Alice M. Sharpe, Edith C. Thomas; to Station Hospital, Jefferson Barracks, Mo., 2nd Lieuts. Keziah Hibbard, Kathryn Lowes, Beatrice Watts; to Station Hospital, Fort Monroe, Va., 2nd Lieut. Martha L. Streeter; to Station Hospital, Fort Riley, Kans., 2nd Lieut. Katherine C. Keegan; to Station Hospital, Fort D. A. Russell, Wyo., 2nd Lieut. Daisy M. Sheahan; to Station Hospital, Fort Sam Houston, Texas, 2nd Lieuts. Lottie Blackmore, Ellen Whalen; to Station Hospital, Fort Hill, Okla., 2nd Lieut. Mabel A. Watkins; to Station Hospital, Fort Slocum, N. Y., 2nd Lieut. Sara A. McLaughlin; to Walter Reed General Hospital, Washington, D. C., 2nd Lieuts. Grace L. Whitehead, Inez Hahn; to Station Hospital, Fort Totten, N. Y., 2nd Lieut. Dorothy Franke; to Hawaiian Department, 2nd Lieut. Minnie G. McLemore.

Seven have been admitted to the Corps as Second Lieutenants.

The following-named are under orders for separation from the Corps: Helen M. Jones, Jane A. Cleland, Bertha M. Shelton, Carolyn Furst, Frances L. Meehan, Lee E. Williams, Rae I. Kennedy, Marguerite Rietveld, Margaret M. D'Andrea, E. Geneva Cable,

Jeanine K. Buckley, Rose Wenk, Esther Russell, Margaret H. Cain, Regina S. Berg.

BLANCHE S. RULON,
*Captain, Army Nurse Corps,*
*Acting Superintendent.*

## Navy Nurse Corps

*Appointments:* During the month of May, eight nurses have been appointed and assigned to duty.

The following transfers were made: To Guantanamo Bay, Annie A. Wayland, Chief Nurse, Elizabeth H. Beall; to Haiti, Mary E. Moore, Chief Nurse, Lillian R. Pieper; to Norfolk, Va., Lucy H. Russell; to Portsmouth, N. H., Theresa E. Wilkins, Chief Nurse, Mary E. Noone; to Puget Sound, Wash., Lillian R. Cornelius; to Quantico, Va., Annie B. McPhail; to U. S. S. Relief, Helen Ballentine, Marion Washtel; to Washington, D. C., Dispensary, Navy Yard, Irene Robertson, Chief Nurse.

The following nurses have been separated from the service: Ethelda A. Russell, Elsie C. Tasker, Wilma G. Berry, Bess Grace Hood, Mary M. Butler.

Transferred to Retired List; Alice M. Gillett, Chief Nurse.

J. BEATRICE BOWMAN,
*Supt., Navy Nurse Corps.*

## U. S. Public Health Nursing Service

*New Assignments:* Five.

*Transfers:* To Boston, Mass., Bennetta Tobin; to Buffalo, N. Y., Mary McLarney; to Chicago, Ill., Myrtle Brown; to Stapleton, N. Y., Estelle Hazlewood, Sarah Helen Brown; to New Orleans, La., Mary Cunningham; to San Francisco, Calif., Agnes Corcoran.

LUCY MINNEGERODE,
*Supt. of Nurses, U. S. P. H. S.*

## U. S. Veterans' Bureau

REPORT OF NURSING SERVICE, MAY, 1929

*Separations:* Thirty.

*Assignments (New):* Twenty-four.

*Reinstatements:* Ivy Lennon, Celeste Smith, Inez Qualey, Rena M. Leach, Mabel Gray, Lydia Rankin.

*Transfers:* Helen K. Smith, to San Fernando, Calif.; Susie Gear, to Livermore, Calif.; Anna Daley, to Walla Walla, Wash.; Clare Quinlan, to Ft. Harrison, Mont.; Ethel Houston, to Dwight, Ill.; Florence Yeiter, to Outwood, Ky.; Ethel Ross, to Legion, Texas; Frances Hawthorne, Mildred Maier, Helen J. Sturrock, to Hines, Ill.; Theresa Just, to Portland, Ore.; Lizzie Grant, to St. Cloud, Minn.; Esther Julian, to Knoxville, Iowa; Selma Gilbertson, Gertrude Hasenjaeger, to Fargo, N. D.; Anna Jennings, to Jefferson Barracks, Mo.; Katherine McGee, to Memphis, Tenn.; Helen L. Droesbeck, to Tucson, Ariz.

MARY A. HICKEY,
*Supt., of Nurses, U. S. V. B.*

## The Indian Bureau

REPORT FOR TWO MONTHS

*Appointments:* Twenty-two.

*Terminations:* Eleven.

*Transfers:* to Fort Thompson, S. D., Frances J. Weller; to Charles H. Burke School, Fort Wingate, N. M., Mathilde Cornelius.

ELINOR D. GREGG,
*Supervisor of Nurses.*

## A Graduation in France

THE AMERICAN HOSPITAL OF PARIS held graduating exercises for a class of twenty-five on June 7.

## International Catholic Guild of Nurses

FIFTH ANNUAL CONVENTION, MONTREAL, CANADA, JULY 5-7, 1929

*July 5*, 8.30 a. m., Mass and Holy Communion; 9.45, registration at Headquarters, Mount Royal Hotel; 10, opening session, Lyda O'Shea, President, presiding; addresses of welcome from representatives of ecclesiastical and civic authorities; "Ideals and Achievements of the International Catholic Guild of Nurses," Rev. E. F. Garesché; Symposium on University Affiliations: "The Minimum Standard in University Affiliations with Catholic Nursing Schools," Rev. Alphonse Schwitalla, President of the Catholic Hospital Association; "Obligations and Privileges of University Affiliations for Nursing Schools," Rev. Walter G. Summers, Regent, School of Medicine, Georgetown University, Washington, D. C.; "A Practical and Satisfactory Affiliation," Sister Helen Jarrell,

Director of Nursing Education, St. Bernard's Hospital, Chicago; "Scholarships for Nurses," Elizabeth A. Grenier, Principal, School of Nursing, Mt. Sinai Hospital, New York City.

12 noon, luncheon; roll call of countries; address, "Catholic Montreal, Past and Present," speaker to be announced.

2 p. m., afternoon session, Miss O'Shea presiding; "Leadership," Helen R. Y. Reid, Victorian Order of Nurses, Montreal; "Possibilities in Medical Social Service," Rev. Matthew Fortier, Dean, School of Sociology, Fordham University, New York; Question Box, Open Forum: "Methods and Problems of Teaching," Sister John Gabriel, Educational Director, Sisters of Providence in the Northwest, Seattle, Wash.; "How to Arouse Interest in Professional Activities," Miss Colston, Cleveland, Ohio.

8 p. m., Esther Tinsley, Vice-President, presiding; "The President's Message," Lydia O'Shea; "The Social Aspects of Nursing, Rev John P. Boland, D.D., Buffalo, N. Y.; "The Duty of the Community to the Nurse," John A. McNamara, Editor, the *Modern Hospital*, Chicago, Ill.

*July 6*, 8.30 a. m., Mass and Communion; 10, Esther Tinsley presiding; "Leadership in the Field of Nursing," Sister John Gabriel; "Significance of the Grading Committee's Work," Laura R. Logan, Chicago, Ill.; "Opportunities for the Properly Prepared Public Health Nurse," Agnes O'Halloran, Department of Health, Harrisburg, Pa.; "Present Standards of Nursing in Government Service," Mrs. Mary A. Hisbey, U. S. Veterans' Bureau.

12 noon, luncheon; address, "The Care of Ex-Service Men and Nurses," Annie J. Hartley, Matron-in-Chief, Department of Pensions and National Health, Toronto, Canada.

2 p. m., afternoon session, Miss Colston, Second Vice-President, presiding; "The Private Duty Nurse as a Health Teacher," Edith B. Hurley, Professor of Public Health Nursing, University of Montreal, Montreal; "The Relationship of the Curriculum to the Efficiency of the Nurse," Margaret Tracy, Yale School of Nursing, New Haven, Conn.; "Public Health Nursing and Citizenship," Harriet Palmer, Supervisor of Rural Service, Cook County, Chicago, Ill.; "Public Health Nursing in Germany," Agatha Sandtobler, Chief of Health Nursing Service, Province of Schwaben and Neuburg, Germany; "Guild Organization and Local Chapters," Margaret Malloy, Executive Secretary, International Catholic Guild of Nurses, Chicago; Annual business meeting.

*July 6*, 2.30 p. m., sectional meeting, Agnes Jamieson, Chairman, Private Duty Section, Canadian Nurses' Association, presiding. "The Relationship of the School to the Alumnæ," Caroline V. Bassett, Royal Victoria Maternity Hospital, Montreal; round table on "Private Duty," Miss Jamieson presiding. "Private Duty from the Standpoint of the Nursing Administrator," Sister M. Giovanni, St. Joseph's Mercy Hospital, Ann Arbor, Mich.; "Group Nursing," Mary I. Walsh, St. Mary's Mercy Hospital, Gary, Ind.; "Private Duty," Miss Molly Dempsey, Albany, N. Y.; discussion, Helen F. Gregory, Germantown, Pa.; 5 p. m., banquet for Sisters, Hotel Dieu Hospital; 7 p. m., annual banquet, Mount Royal Hotel, honorary guests, Nina D. Gage, R.N., President, International Council of Nurses; Mabel F. Henry, R.N., President, Canadian Nurses' Association; S. Lillian Clayton, President, American Nurses' Association; clergy by invitation.

*July 7*, 10 a. m., round table on "Retreats for Nurses," conducted by Father Gerouche; 11, Solemn High Mass, Notre Dame Church; 2 p. m. conference on "Organization and Procedure for Promoting the Spiritual Life;" 3, tea and reception, Auxiliary of St. Mary's Hospital, hostesses, Loyola College; 7.30, conference and benediction.

*July 8*, Day of Spiritual Recollection for Nurses. 8.30 a. m., Mass and Communion with conference; 11 a. m. and 3 p. m., conferences; 7.30 p. m., conference and benediction.

### *State Boards of Examiners*

California: The California legislature during the past three months has been the seat of battle to obtain measures necessary for public welfare and health. The result of the battle was not a victory for social workers or nurses. The former hoped to get a bill approved for the licensing of persons in social work. Although well sponsored, it did not gain passage, and died with other welfare measures. This would have affected nurses and others in the many varied fields of social work.

The nurses of California were quite venturesome, and presented three bills: one to license practical nurses, another changing the present Nurse Registration Act, and a third to transfer $30,000 of the unexpended balance in the fund for the registration of nurses to the Chair of Nursing Education. The first bill was opposed by the commercial employment agencies on the ground that it would flood the supply to the question. The opposition was also directed against the official licensure of nursing service. The propaganda put out very much

bolstered the legislature and did harm to the Nurse Registration Bill. It was, therefore, withdrawn by the Legislative Committee of the State Association in order to clear the way for the Nurses' Registration Bill. The changes proposed in the Nurses' Registration Act were necessitated in order to comply with the Governor's plan in creating a department for all licensing boards, much the same as at present in Illinois. The contemplated change was to remove the Bureau of Registration of Nurses from the State Department of Health to this new department of Professional and Vocational Standards, and to create a Nurse Board of Examiners which would maintain jurisdiction over examination, inspection and accrediting of schools of nursing. There were other features, such as reduction of fee from $10 to $5, raising the requirements of admission to schools of nursing to high school, and reducing the age requirement for examination to twenty years and six months. The opposition came from the State Medical Society and was strongly maintained throughout the session, despite the fact that the Legislative Committee agreed to meet the opposition which centered on an entire Nurse Board, and accepted a board of two nurses, two physicians and one educator. Consequently the bill failed in committee, and the administration of the Nurse Registration Act remains with the State Department of Public Health.

The third bill was not difficult to get through; the legislature understands transfer of funds better than standards for the profession. The bill passed, and there will be added to the endowment of the Chair of Nursing Education at the University of California a sum sufficient to bring the total endowment to $100,000.

While the results of this legislative session just closed have been disappointing to the nurses of the state and other professional workers, the experience, nevertheless, has taught a lesson in political intrigue and technic which will serve in the coming two years of preparation for the next legislature.

**South Dakota:** Because of an amendment recently secured, all nurses registered in South Dakota are notified that the state law requires each nurse to renew his or her license on or before the first day of July each year, by sending to the Secretary of the Examining Board, Rapid City, the required fee of one dollar. Every certificate of registration which has not been renewed during the month of July in any year shall expire on the 31st day of August in that year. This is effective July 1, 1929.

**Washington:** Examinations for registration of nurses in Washington will be held July 22 and 23, in the Stimson Building, Seattle, and in Spokane. For further information, write to the Secretary of the Department of Licenses, Olympia.

## *State Associations*

**Massachusetts:** The Massachusetts State Nurses' Association held its twenty-sixth annual meeting, on June 8, in the new building of the Young Women's Christian Association, Boston. The different subdivisions, namely, the Massachusetts League of Nursing Education, the Public Health Nurses' Section, and the Private Duty Nurses' Section, held their annual business meetings in the morning. At each session, after the election of officers and the transaction of other business, addresses were given and discussions held on subjects of peculiar interest to the Section.

The annual business meeting of the Association took place in the afternoon. In addition to the reports of the year's work presented by the different officers and chairmen of committees, the program included an address by Mrs. W. O. Fiskham, Executive Secretary of the Massachusetts Civic League, on "The Proposed Work of the Children's Commission," a commission created by an act of the legislature of 1929 to investigate laws relative to dependent, delinquent, and neglected children, or others requiring special care.

The chairman of the committee for the administration of the Relief Fund, Mrs. Albert, in an interesting yearly report, urged the need of larger contributions, in order that this beneficent work for sick or otherwise unfortunate members of the profession might be extended beyond what the present resources permit. The report of the Speakers' Bureau contained a significant item, to the effect that the Bureau, which has hitherto been seeking to enlist the interest of young women in nursing as a profession, has this year directed its efforts into a different channel, and is now emphasizing the importance of more thorough preparation by way of liberal education as a basis for training in the specialized field of nursing. The adoption of this policy is, no doubt, a result of the work of the Grading Committee. The Harmon plan, designed to provide insurance for nurses, was briefly described by Carrie M. Hall, who said that, since the publication of the article in regard to the Harmon plan in the March issue of the *Journal*, one hundred and seventy-eight

nurses had availed themselves of this opportunity to provide for old-age support. Miss Hall recommended the subject to the careful consideration of all nurses. The State Committee of the Red Cross Nursing Service reported that $200 had been contributed to the Memorial School of Nursing at Bordeaux, France. The absence of any attempt to obtain makeshift legislation of direct concern to the nursing profession in Massachusetts has given the members of the Legislative Committee a full year's holiday. A vote was passed whereby the fiscal year of the Association, which has hitherto been from June 1 to to May 31, shall coincide with the calendar year, thus beginning January 1 and ending December 31.

Of especial interest was the report of the new Executive Secretary, this being the first annual meeting since the creation of that office, with the appointment of Helena G. Lee, who stated that her plan of work had thus far been carried on along three lines, namely, routine duties, compiling function, and field service. She has maintained an extensive correspondence not only with alumnæ associations and superintendents of nursing schools, but also with individual members of the Association. With a view to making the headquarters a bureau of useful information, she has collected a store of pertinent facts,—now on file for the use of all interested persons,—together with literature prepared by the American Nurses' Association, state laws and regulations in which the profession is concerned, and other related data. March, April, and May were devoted chiefly to field work; speaking before alumnæ associations, high schools, and other groups, where she has had contact with prospective students, as well as with students already enrolled in nursing schools. An announcement of a somewhat unusual nature was that the expenses had thus far been kept well within the estimate made by the Headquarters Committee, and this without impairment of the work. One of her chief objectives during the coming months would be the establishment of closer relationship between her office and the members, individual and group, of the Association. A similar aim will be to bring in new members, thus making the State Association of greater influence and help in every field of nursing in Massachusetts, and thereby in the entire community which the nursing profession seeks to serve.

In the intermission between the morning and afternoon sessions, about thirty persons visited the new headquarters at 420 Boylston Street. At the close of the meeting a tea was given in one of the drawing rooms of the Young Women's Christian Association Building. Miss Johnson from the Central Directory was on duty throughout the day to answer questions and to receive subscriptions to the *American Journal of Nursing*. Seventeen new subscriptions were received. Officers elected to serve during the coming year are: President, Bertha W. Allen; vice presidents, Sally Johnson, Ellen C. Daly; recording secretary, Mary Alice McMahon; corresponding secretary, Elizabeth Ross; treasurer, Emma M. Nichols.

At the annual meeting of the Massachusetts League of Nursing Education, held in Boston, June 5, the following new officers were elected: Vice president, Susie A. Watson; secretary, Gertrude E. Maloney; director, Helena G. Lee. Those remaining in office for another year are: President, Ellen C. Daly; treasurer, Mary L. Wakefield; directors, Sally Johnson and Blanche Blackman.

Montana: The Montana State Association of Graduate Nurses, also the Northwest Division, meet this year in Great Falls, July 29–31. The State Association will hold its meeting the afternoon of the 31st. Since the election of officers at the last annual meeting, both the President and First Vice President have left the State, so the Second Vice President, Lydia Gudmunsen, of the Murray Hospital, in Butte, will preside the afternoon of the State meeting.

New York: Caroline Garnsey, Executive Secretary of the New York State Nurses' Association, is resigning her position on August 1; she has not fully recovered from the accident of last fall. She is succeeded by Emily J. Hicks, who has been for several years Superintendent of Nurses at Faxton Hospital, Utica.

Oregon: The annual meeting of the Oregon State Association was held in the Chamber of Commerce Rooms, Salem, June 6, with the following program: Invocation, Norman K. Tully, D.D.; addresses of welcome, Mayor Livesley; Grace L. Taylor; response, Minnie G. Crowe. 10 a. m., business meeting. 11.30, demonstration of work in State School for the Deaf, J. Lyman Steed. Noon, luncheon, address by Dr. Helen M. Gilkey on "Conservation of Our Wild Flowers."

1.45 p. m., Clinic at the State Hospital for the Insane; 3.15, Clinic at the State Tuberculosis Hospital. Officers elected are: President, Jane Gavin; vice presidents, Helen McCusker, Margaret Price; secretary, Miss

Louise H. Cliff; treasurer, Helen Adamson; directors, Ada Thomas, Glendora Blakely, Ruby Emery Rumble.

The Common Legislation of Nursing Education hold three joint meetings with District 1, Portland, during the year. The first, a series of tableaux and slides, was given at the St. Vincent's Hospital. Representatives from practically every hospital and nursing organization in the city took part. It included tableaux representing historical characters in nursing, the first superintendents' meeting in Chicago, in 1893, the first graduates and those of the present day, the Portland Visiting Nurse Association, then and now, and opportunities in the nursing profession. The program was witnessed by an audience of over two hundred people. The topic of the second program was "Nurses, Patients and Publications," and included a discussion of the report of the study being made on the grading of schools of nursing. It was discussed from the angle of the hospital, the school of nursing, the student nurse, the graduate, the registry and the patient. The last program was put on at the Public Library, and consisted in a talk on "A Traveling Scholarship" by Genevieve Johnson, who was the first nurse to have received this scholarship in this State. This was followed by a motion picture, "Ten Many Pounds," from the Metropolitan Life Insurance Company. The last program of the year was turned over to the public health nurses, and was given on May 20, at the Public Library. League officers elected at the annual meeting are: Vice president, Jane Doyle; secretary, Pauline Knudsen; directors, Grace Quirk, Lotha Humphrey. Officers holding over are: President, Mrs. Emma Jones; treasurer, Lillian Pfanigar; director, Mrs. Belle Bodley.

Vermont: The fifteenth annual conference of the Vermont State Nurses' Association, held in the Aldrich Public Library, at Barre, May 28, was one long to be remembered by the more than sixty nurses present. The morning session was given over to the general routine business of reports from the various officers and committees; also, a most interesting report by Hazel Berry, Superintendent of Nurses, Mary Fletcher Hospital, Burlington, of the sixth convention, New England Division, held at New Haven, in April.

The day was fine, adding much to the enjoyment of the auto trip, after lunch, to the largest granite quarries in the world, and a visit to the tuberculosis sanitarium, high up in the hills. After returning Lillie Young, the outgoing President, gave a most interesting reminiscence. Elizabeth Cain's charming way of presenting her work with the unmarried mother, at the Elizabeth Lund Home, Burlington, made one almost envy her position. Dr. J. H. Woodruff gave a very fine paper on "Some Medical Masters," and then came section meetings, and report of tellers. At the end of the afternoon session, tea was served at the Nurses' Home of the Barre City Hospital.

The evening session was in the form of a banquet at Hotel Barre. The Harmon plan of "Annuities for Nurses" was presented at this time by a representative of the Metropolitan Insurance Company.

## *District and Alumnae News*

Alabama: Birmingham.—Seventy-five Senior Nurses from the Birmingham Schools of Nursing Education were honor guests at the annual banquet given them by District 1, May 29, at the Hollywood Country Club. Dora M. Cornelison, Field Representative of the *American Journal of Nursing*, was a guest of honor. Green candle sticks with green candles, green place cards with names written in white ink, subtle reminders of the *Journal*, were used. Each honor guest received a copy of the Nightingale Pledge as it appeared in the May issue of the *Journal*, the gift of their respective alumnae. Every member present received a *Journal* scratch-pad sent by the *Journal*, also a little folder reminder of the *Journal*, a greeting and welcome to the young graduates, also a reminder that we are to be hostess to the Southern Division in October. The following program was enjoyed by over two hundred members: Invocation—Rev. Vernon E. McMasters; Greetings by Annice Jackson, District President; "The Southern Division Meeting," Annie Mae Baddley, State President; "Social Aspect of Nursing," Dr. K. R. Barnhardt; "The Nurse in Modern Life," Dr. J. S. Thomas. Commencement exercises for the class of 1929, St. Vincent's Hospital, were held on the evening of June 6, when an address was given by Bishop Toolen to the eight graduates. The regular meeting of the Alumnae Association, in May, was given over to a talk by Dora M. Cornelison.

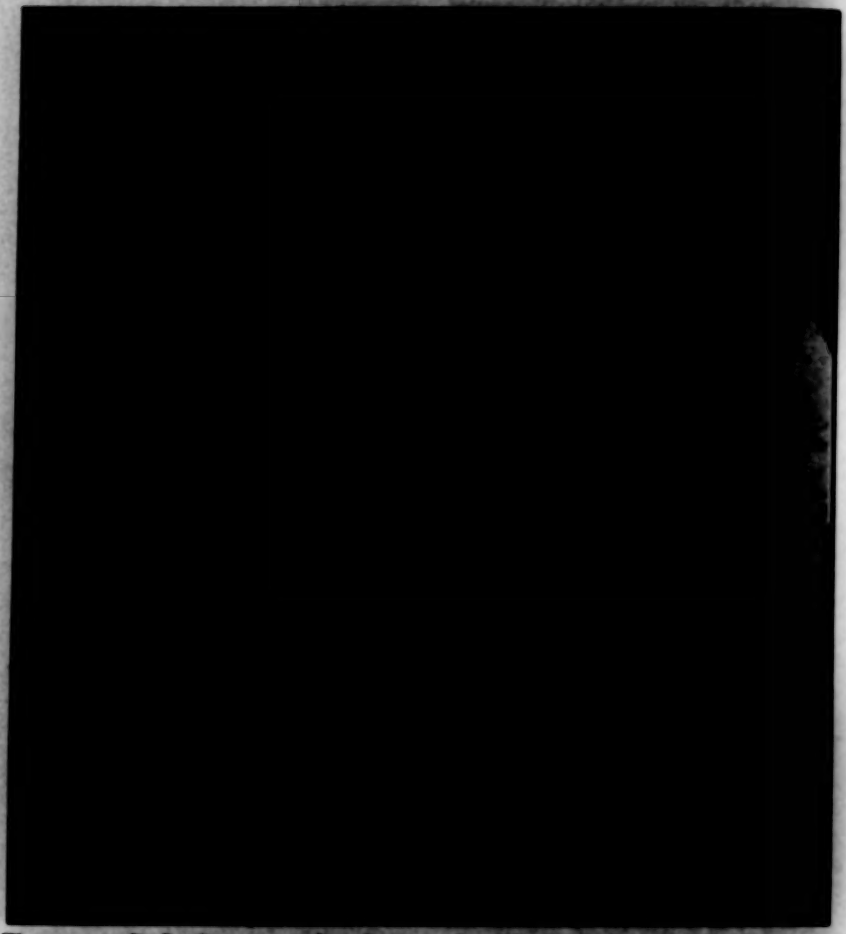
California: Los Angeles.—St. Vincent's Hospital held graduation exercises for a class of twenty-four, on May 15. The address was given by Rt. Rev. J. J. Cantwell, D.D.

Connecticut: New Britain.—The New Britain Hospital held graduation exercises for

the nineteen members of the class of 1920, in the State Normal School Auditorium, on May 28. The address was given by Hon. Alice P. Merritt.

District of Columbia: Washington.—The Army School of Nursing held graduation exercises, on May 31, in the Army Medical Center, for a class of forty-two. Addresses were made by Major General Merritte W. Ireland and Colonel Francis A. Winter.

Georgia: Augusta.—The Second District held a meeting on May 13 at which, after the business session, a talk was given by the State Executive Secretary, Jane Van De Vrede, on matters of mutual interest to the state and the district. Columbus.—The



Washington, D. C.—Providence Gen. Emerson Rea Medal and $100 to Army School of Nursing Graduate Emerson

Mrs. Henry B. Rea of Pittsburgh, Pa., pinning the Rea Medal on Melvina M. Grieves of Providence, R. I. The medal is awarded annually to the girl who has shown the greatest natural aptitude for her work, not only from the lessons learned from books, but also for human understanding, cheerfulness and optimism. Miss Grieves also received $100 cash prize.

regular meeting of the Fifth District was held, on June 7, in the Parish House of Trinity Church. At this meeting, the last until after the summer season, there was a general discussion as to what was necessary to put the Fifth District over the top. A representative of each group of nurses spoke: Private Duty, Hospital, Public Health, Industrial and Office. It was the consensus of opinion that active cooperation by all members will result in reaching the goal. Gainesville.—The Nurses' District was organized on May 16, with a temporary organization. On May 23, the following officers were elected to serve for the calendar year: President, Dorothy Smith; vice president, Mrs. Caroline Norton Bailey; secretary, Frances Lowe; treasurer, Ruby Falls. Hortense Jones, is chairman of the Board of Directors. At this meeting constitution and by-laws were adopted and other business transacted, nineteen members being present. The Denison Hospital Alumnae Association was organized, on May 16, with temporary officers. Savannah.—The Fourth District held a meeting on May 20, Martha Gotcher, presiding. The speakers were Dr. Reichelt and Lucy Hall, a former state president. The Committee on the Linen Chest reported receipts of $170, and the Yearbook Committee a total of $244.50 advertisements secured.

Illinois: Chicago.—The Illinois Training School, held graduation exercises for its last class, of thirty-five members, on June 11, at Murphy Memorial Hall. Dr. May Ayres Burgess was the speaker. Wesley Memorial Hospital held its commencement exercises in Evanston as part of the Northwestern University exercises, on June 17, for a class of thirty. Decatur.—The Decatur and Macon County Hospital held graduation exercises for the sixteen members of the class of 1920 at Millikan University Auditorium, on June 4.

Indiana: Fort Wayne.—The Lutheran Hospital School of Nursing held commencement exercises on May 15, when twenty-five nurses received diplomas. Doctor Beaumont S. Cornell of Ft. Wayne was the principal speaker; Rev. John Berthel also addressed the class.

Iowa: Council Bluffs.—Fourteen nurses were graduated from Jennie Edmundson Hospital on May 14. Dr. M. A. Tinley gave the commencement address. Commencement exercises for the twelve seniors of Mercy Hospital, occurred May 23, in the hospital chapel. The Reverend Agnew, President of Creighton University, Omaha, gave the address. The alumnae of Mercy Hospital published its first monthly bulletin in May. Mary Kubitschek is editor. Des Moines.—The annual picnic of Seventh District was enjoyed, June 6, at The Cabin in Greenwood Park. This is the last meeting of the district until September 5, when the public health nurses will have charge of the program. Sioux City.—The May meeting of District One was held on the 22nd, in the form of a dinner. Mrs. D. Fiske-Boyce, health lecturer of the State Department of Health, was the speaker. St. Joseph's Hospital commencement exercises were held at the nurses' home, May 14, when twenty-six Seniors received their diplomas.

Kansas: Abilene.—The Fifth District held a meeting on June 1 in the Auditorium. Mrs. Martin of Clay Center was one of the speakers. Lawrence.—A joint meeting of Districts 1 and 2 was held on June 11, in Pinckney Park, a business meeting of District 1 being held at the City Hall. Members of District 1 were hostesses.

Maine: Portland.—The Maine Eye and Ear Infirmary held commencement exercises for a class of fourteen on June 3. Dr. E. E. Holt, Jr., gave the address.

Massachusetts: Marlboro.—Minnie O. Robbins, Superintendent of the Marlboro Hospital, has just completed twenty-five years of faithful service as superintendent of that institution. On June 5, the trustees of the hospital presented her with a gold medal and $600 as a token of their appreciation for the wonderful work she has done as superintendent. Springfield.—The Springfield Hospital held commencement exercises for a class of twenty-four on May 24. Worcester.—Graduation at the Worcester State Hospital was held on June 19, for a class of four.

Michigan: Hancock.—St. Joseph's Hospital Alumnae at their annual meeting elected: President, Anabell Campbell; vice president, Anna Sundstrom; secretary, Mrs. Ray Hosking; treasurer, Beatrice Michels.

Minnesota: Minneapolis.—The Fairview School of Nursing held graduation exercises for a class of thirty-two, on May 28, in the Bethlehem Lutheran Church. The Ninth Ward Citizens' Association announced the purchase of the Ethel Hospital, one of the finest private hospitals in the Northwest. Three additional stories, including a roof garden, will be added to the present six-story structure, allowing a capacity of 120 beds. The School of Nursing which

has been conducted in connection with the hospital will be continued for an indefinite time. Rochester.—St. Mary's Seminar of Nursing held commencement exercises for a class of fifty-six, in St. Mary's Auditorium, on June 3.

Mississippi: Laurel.—Seventeen of the graduates of the Mississippi Charity Hospital met on April 15 in the Nurses' House, and organized an alumnæ association, aided by Ida L. Hood, who acted as chairman, and by Mrs. Maude R. Varnado, Secretary of the Examining Board. Mrs. Varnado spoke very interestingly on "The Value of an Alumnæ Association." The superintendent of the hospital, Dr. R. H. Foster, and the former superintendent, Dr. R. H. Crawford were present. Officers elected are: Honorary President, Annie Mae Gatlin; president, Mrs. Ina Windsor Lowell; vice president, Elsie B. LeGuin; secretary, Matilda Mae Pigue; treasurer, Mrs. Gladys R. Price; reporter, Mrs. Alma Y. Cox; chairman of Committee on Constitution and By-Laws, Bertie G. Jones; membership, Mrs. Sarah D. Vance. A meeting of the Association will be held every three months.

Missouri: Kansas City.—The Kansas City General Hospital Nurses' Alumnæ Association elected the following officers at their annual meeting: President, Florence Gallant; vice president, Anna Carlson; secretary, Gertrude Stumpf; treasurer, S. Blake Fowler. Kirksville.—The annual meeting of the Lawrence Hospital Alumnæ was held on May 24 at the Stephenson Hotel, in connection with the annual banquet. Officers elected are: President, Edna Hamilton; vice president, Margaret Bruns; secretary-treasurer, Hazel Fisk. St. Louis.—Washington University, including the School of Nursing, held commencement exercises on June 11, in Field House, for a class of thirty-one. The address was given by John Charleton Jones. With the last payment, the first deed of trust on the Teuse Dunsany's club house was cancelled, and the club is now the property of the nurses. The bonds that belonged to two nurses who had entered into rest were purchased from their estates by the District. Commencement exercises are virtually over. The schools graduated classes as follows: St. Louis Baptist, eight; City, twenty-three; Jewish, twenty-one; Josephine, five; Lutheran, sixteen; St. John's, twenty-eight; Missouri Baptist, thirty-five; St. Luke's, thirty-five. The Jewish Hospital dedicated its new nurses' home, The Moses Shoenberg Memorial, on June 9. Dr. Frank Vizetelly was the chief speaker.

Montana: Missoula.—A class of eight graduated from St. Patrick's Hospital on June 27.

New Hampshire: Claremont.—The Claremont General Hospital Alumnæ held its annual meeting, May 24, and elected: President, Clara E. Hutchings; vice presidents, Mrs. Lillian Coles and Susan G. Sligo; secretary, Maude F. Edwards; treasurer, Mrs. Clara H. Rice; directors, Dessie M. Wood, Flora F. Mann, Ethel Foote. It was an interesting meeting with more members present than usual, followed by a banquet in the evening. Manchester.—The quarterly meeting of the Elliott Hospital Alumnæ was held, May 8, at St. Ursula's Training School, Mrs. Davis presiding. The question of membership in the Catholic Nurses' Guild was discussed, and it was decided to try to interest other Catholic nurses of the city in the project. Miss Stevens and Mrs. Davis gave reports of the New England Division Meeting.

New Jersey: Atlantic City.—At the graduation exercises of the Atlantic City Hospital, held June 5, the speakers were Dr. William J. Carrington, Dr. Robert A. Hildreth, and Rev. Henry M. Fisher. There were eighteen graduates. East Orange.—The commencement exercises of the School of Nursing of the Homœopathic Hospital took place on May 16 at the Church House of the First Presbyterian Church. There were twelve graduates. Plainfield.—Muhlenberg Hospital School for Nurses held graduation exercises and celebrated its thirty-fourth anniversary on June 12, at the Hotchkiss Auditorium. There were nine graduates. Trenton.—The Mercer Hospital held graduation exercises for the class of 1920 on May 24.

New York: Auburn.—Dunsany 4 held a meeting at Auburn City Hospital on June 10. A very interesting program was provided: Miss Charlotte Hudson, New York State Field worker for the American National Red Cross, gave a splendid talk on the relation of the individual nurse member to the National Association. There was also a short travel talk by Helen Rutledge, describing especially an Montreal and the trips to be had in connection with the International convention. The next meeting will be September 9, at Syracuse Memorial Hospital. Binghamton.—Members of Dunsany 5, from four counties, to the number of 102, held a meeting at dinner, June 5, in the Elks' Roof Garden. The address of welcome was given by the President, Jeannette

P. Simon. The presidents of the hospitals of the District were guests, as were the members of the graduating class of the Johnson City General Hospital, Buffalo.—The Children's Hospital held graduation exercises for the class of 1929, on June 6, at the nurses' residence, Cincinnati.—The Pennsylvania Women Temporary Hospital held graduation exercises for the class of 1929 in the Congregational Church on June 14. The commemoration of the twenty-fifth anniversary of the founding of the hospital was marked by a reception following the exercises. Clifton Springs.—The Clifton Springs Sanitarium and Clinic Surgical or Nurses' Training School held commencement exercises on June 13, in the chapel, for a class of thirty-two. The address was given by Rev. Andrew Clifton of Rochester. New Rochelle.—Graduation exercises of the class of 1929 of the New Rochelle Hospital were held on June 6, at the Women's Club. Addresses were given by Ralph S. Hunt, Dr. Eugene T. Monahan and Jared M. Gilder. New York.—Lincoln Hospital held graduation exercises for a class of forty-three, on May 15. The address was given by Dr. Robert R. Moton, Principal of Tuskegee Institute. The Metropolitan Hospital held commencement exercises for the class of 1929 on May 28. St. Mark's Hospital held graduation exercises for a class of seven, on May 28, at St. Mark's in the Bouwerie Church. The address was given by George Odell Moss. The probation class was accepted at the same time.—Oneida.—On May 28, graduation exercises for a class of nine were held by the Bruce Sumner Hospital, at the Odd Fellows' Temple. The address was given by Miss Genevieve Clifford. Port Chester.—Commencement exercises for a class of twelve were held by the Universe Hospital, on May 28, at the hospital. The address was given by Morton Snyder. Rochester.—The Strong Memorial Hospital of the Medical School of the University of Rochester has raised $600 for the Nurses' Relief Fund, by a card party held at the Nurses' Home of St. Mary's Hospital. At the annual meeting of District 2, it was reported that $615 had been contributed during the year to the Relief Fund. Rochester.—Graduation exercises were held in convention hall, on May 23, for the Highland Hospital, a class of twenty-five; for the Rochester German Hospital, a class of forty-eight; for the Genesee Memorial Hospital, a class of twenty-one; and for the Genesee Hospital, a class of twenty-six. The address was given by Rev. John Timothy Stone, D.D., of Chicago.—Graduation exercises were held in the John F. Hughes School, on May 28, for the Faxton Hospital, a class of thirty-two; for the Utica Memorial, a class of six; and for the Utica State, a class of five. The address was given by Dr. Alfred E. Alton of Colgate University.

North Carolina: Durham.—The regular meeting of District 8, the Durham Nurses' Association, was held on May 14, with twenty-nine members present. A report from State Headquarters showed that this was the first association in the state to pay its quota for the Grading plan. After a business session, the picture, "History of Nursing" was shown. The Watts Hospital Alumnae held a meeting on May 9, with thirty members present. Officers elected for the coming year are: President, Mrs. Emily Pickard; vice president, Mrs. W. F. Rogers, Vera Ray; secretary and treasurer, Maude Miller. The graduation exercises of Watts Hospital were held, on May 9, at Duke University Auditorium. Dr. Owen Moore made the address. There were twenty-two graduates. Winston-Salem.—District 2 holds meetings every second Thursday, at the Y. W. C. A. Attendance this year has been unusually good, from thirty to forty-five members at each meeting. Twenty new members have been received since January 1, bringing the total to 160. The District has as its objective a Nurses' Club House. So far, $112.52 has been made this year from a dance and rummage sale, bringing the total to well over a thousand dollars. The District goes on record as endorsing the Newton Bill; also it is thoroughly in sympathy with the work being done by the Grading Committee, and has contributed liberally to its financial support. The Program Committee is a very active one, bringing something different at each meeting to attract the members, such as lectures, music, readings, and contests. A social half-hour is always enjoyed. Rapid progress has been made under the able leadership of Lelia Idol, President, reelected for the fourth time in January.

Ohio: Lima.—The Alumnae Association of the Lima Hospital publishes a bi-monthly paper which they would like to exchange for other alumnae publications. Address Bernice Thomas, 1115 Elm Avenue.

Oregon: Portland.—Jean Busby has resigned as Health Education Director of the Oregon Tuberculosis Association. She will be succeeded on September 1 by Henrietta Marsh.

Pennsylvania: Altoona.—The annual commencement exercises of the Altoona General Hospital were held in Jaffa Temple, on

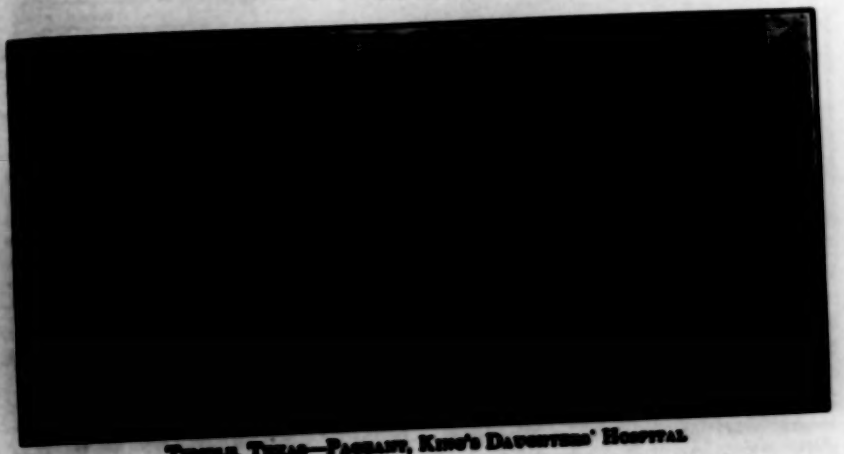
May 23, when a class of fifteen nurses received diplomas. At the dinner given by the alumnæ to the graduates, Miss Rudolph, a graduate of Johns Hopkins, gave a short but very pleasing talk. Hendersonville.—The Nonnewtown State Hospital held commencement exercises for a class of thirteen on June 12. The address was given by Miss S. M. R. O'Hara, Deputy Attorney General of the State. Philadelphia.—At the sixth annual banquet of the Samaritan Hospital Alumnæ, May 12, addresses were made by Dr. Charles E. Beury, Dr. Parkinson, and Dr. Minehart. It was announced that the alumnæ registry will be retained in the hospital, and Samaritan nurses will be given first choice when calling a nurse into the hospital. The new medical school will soon be started and, as soon as possible, efforts will be made to build a new nurses' home. The First District Association met at the Presbyterian Hospital on May 28. The Committees on History of Nursing Fund and American Nurses' Memorial at Bordeaux reported successful activities. The Committee on Relief Fund reported a plan to visit monthly those members being helped, in the First District. Also that plans were being made to promote insurance among nurses. The Official Directory of the First District Association was established on April 29, and in one month had 163 members. Alumnæ associations and hospitals have shown admirable cooperation. After the business meeting, the members attending were taken to the splendid new classrooms of the Presbyterian Hospital School of Nursing. Under the leadership of Anna Meier, several demonstrations of Medical Nursing Procedures were admirably presented by students of the school. A class of twenty-seven was graduated from Harrisburg Hospital on April 30. The address was given by Rev. Robert H. Gearhart, Jr. The 30th anniversary of the graduates of the School of Nursing of the hospital was held on May 29, at the Elks' Club. There was an attendance of 175, almost every class being represented. Dr. H. P. Leopold was the guest of honor. Pittsburgh.—The regular meeting of the Sixth District Association was held in the Chamber of Commerce Auditorium, May 22. Nearly six hundred nurses were present. Twenty-five names were submitted by the Eligibility Committee and were accepted by the District. It was voted that District 6 should have their headquarters and full control of the property formerly owned by the Nurses' Club on Fifth Avenue. The new Code of Ethics was read and discussed. Nominations for the preferential ballot were completed for the state convention to be held at York. The matter of establishing sub-divisions in the District was brought up and discussed. York.—The Instructive for Board Members of Public Health Nurses Qualifications which was postponed January 21, on account of the influenza epidemic, will be held October 24, beginning 10.30 a. m., at the Visiting Nurse Association Headquarters, 216 East Market Street. Anna M. L. Huber, President of the York Visiting Nurse Association, is chairman. An announcement of the program will be made in the September issue.

Philippine Islands: Manila.—The Philippine General Hospital and the University of the Philippines held commencement exercises for the School of Nursing of the Philippine General Hospital (forty graduates), also the School of Public Health Nursing (twenty-two graduates), and the School of Nursing of the Southern Islands Hospital (twelve graduates), on March 25, on the hospital campus. Addresses were given by Romana S. Tirona, Dean of Women of the University, and by Mathew A. Delaney, M.D., Medical Adviser to the Governor General.

Rhode Island: Newport.—The Newport Hospital held graduation exercises for a class of fourteen, in the Rogers High School, on June 12. The address was given by Mary S. Gardner. Providence.—Dorcas Hospital held graduation exercises for a class of six, on June 7, the address being given by Annie W. Goodrich. The Rhode Island Hospital held commencement exercises in the new Nurses' Home, on June 12, for a class of thirteen.

Tennessee: Memphis.—Eighteen nurses graduated from St. Joseph's Hospital, on May 16. The Baptist Memorial Hospital graduated a class of forty-four on April 13, with exercises held in the First Baptist Church. The address was given by Dr. Robert Q. Leavell of Gainesville, Ga. The Methodist Hospital held graduation exercises for a class of twelve, on May 17, at the Chamber Builders' Hall. Greetings to the class were given by Dr. A. F. Cooper.

Texas: Dallas.—Baylor University School of Nursing held commencement exercises on May 27, in the First Baptist Church, for a class of thirty-six. Houston.—The Baptist Hospital held commencement exercises on May 23, on the hospital lawn, for a class of twenty-seven. Temple.—On May 19 the staff of the King's Daughters' Hospital gave a banquet for the Business and Professional Women's Clubs of Texas, then in



Temple, Texas—Pageant, King's Daughters' Hospital

convention. The students of the school of nursing presented a History-of-Nursing pageant, directed by Nelle P. Buringame, instructor.

Virginia: Staunton.—Commencement exercises for the King's Daughters' Hospital were held on May 28, with an address by Dr. Guy R. Fisher.

West Virginia: Princeton.—Princeton Hospital graduated a class of three on June 12.

Wisconsin: Milwaukee.—The annual meeting of the Fourth and Fifth Districts was held May 14, at Nursing Headquarters, 98 Prospect Avenue. Adda Eldredge spoke on "The Individual's Responsibility in Organization." Fourth and Fifth District has a membership of 726. Of this number, 400 are private duty nurses. There is but one section in the District, that of the private duty nurse; some interesting and, in most instances, well-attended meetings were held. Officers elected are: President, Ethel J. Odegard; vice presidents, Mrs. C. D. Partridge, Lillie A. M. Bennett; secretary, Alice Grant; treasurer, Helen O'Neill; directors, Mrs. George R. Rust, H. Lenore Bradley, J. Marion Kember, Grace Pritchard, Hilma Bolge and Minnie Arndt; trustees, Mary Lalley, Mildred Fuhlbruer, Mary L. Reynolds, Anna Jacobs and Clara Seidler.

## Deaths

Ida Baumgartner (class of 1920, St. Vincent's Hospital, Portland, Oregon), on April 18.

Mrs. Anna Cotter Davis, instructor at the Cambridge City Hospital, Cambridge, Mass., in February, last.

Martha M. Hermeling (class of 1921, St. Louis Baptist Hospital, St. Louis, Mo.), recently, of cerebral hemorrhage. Following her graduation, Miss Hermeling did private bedside nursing, then for three years served as Superintendent of Marshall Hospital at Marshall, Mo. In the fall of 1928, she accepted the position of school nurse, being stationed at Woodriver, Ill. She was found dead at her desk at the school, after completing her day's work. At the time of her death she was Secretary of her alumnae, having served for two years. A true Christian, ever loyal and faithful to her many duties, one could not have known her without being benefited thereby.

Geraldine Mahaney (class of 1917, Johns Hopkins Hospital), at Grace Hospital, Detroit, Mich., April 27.

Susanne Metz (St. Mary's Hospital, Rochester, Minn.), on May 15, from gas poisoning, at Cleveland, Ohio.

Edith Morgan (class of 1905, Lakeside Hospital, Cleveland, Ohio), on May 15, from gas poisoning, at Cleveland, Ohio. Burial was in Youngstown.

Mrs. Louise Stuart Morton (class of 1922, Lakeside Hospital, Cleveland, Ohio), on May 15, from gas poisoning, in Cleveland, Ohio.

Eleanor Ewing Sharkey (class of 1914, Good Samaritan Hospital, Portland, Oregon),

on February 28. Mrs. Sharkey served with Base Hospital 46, overseas.

Ida Frances Shepard (class of 1899, Boston City Hospital), in Hanover, N. H., on May 19. In 1901, Miss Shepard accepted the position of Superintendent of the Mary Hitchcock Memorial Hospital, Hanover, then in its infancy, but developing under her guidance into one of the most important health centers of the state. Her service to this hospital and community covered a period of twenty-seven years. Loved by all with whom she was associated, after a long illness spent in the hospital she loved and served so long, she passed out of this life. Miss Shepard was a charter member and first president of the Graduate Nurses' Association of New Hampshire, and worked earnestly for state registration, serving for several years on the Board of Examiners. Services were held at St. Thomas's Episcopal Church at Dartmouth College, Hanover. Burial was at Concord, her early home.

Mary L. Slayton (class of 1892, Bellevue Training School for Nurses, New York), in Brooklyn, N. Y., April 14. The news of Miss Slayton's death came as a great shock to a large number of devoted friends. Graduating from high school at the age of thirteen and, later, from Mount Holyoke, she displayed superior gifts of learning and a marked ability in the subjects of Greek and Latin. After graduating from Bellevue, Miss Slayton engaged in the work of private duty nursing for several years. In 1901, she accepted the position of registrar for the private duty nurses of the Bellevue Alumnae Association, a position of importance and far-reaching influence, which she held for twenty-four years, resigning in the autumn of 1925. During this time she displayed rare judgment, tact and kindness in meeting the many difficult problems connected with that work; thereby winning the confidence and deep appreciation of a host of doctors and nurses with whom she came in contact. In numerous homes, also, she became almost equally well known for her sterling qualities of heart and mind. The soul of optimism, radiating faith, cheer and courage, Miss Slayton will live in the hearts of many for her enthusiasm and countless acts of sympathy and help to those who sought her advice in times of trouble and perplexity. To all such her passing is an irreparable loss, and she will be deeply mourned by all those whose love and respect she held by her gracious and winning personality. Services were held at Osborn Hall, New York City, on April 16, and were well attended, despite the inclement weather. Burial was at Lebanon, New Hampshire.

Selma Swenson, on May 25, at the William H. Maybury Sanitarium, Northville, Mich.

Billie B. Sowell (class of 1921, St. Joseph's Hospital, Memphis, Tenn.), on April 24, at the Methodist Hospital, after a brief illness. Miss Sowell was a member of the first class to graduate from her school. She was one of the directors of District 1, and was an untiring worker for both the District and her Alumnae Association. Her sunny disposition endeared her to all who knew her, and her death came as a great shock.

Addie Jane Wilder (class of 1912, North Adams Hospital Training School, North Adams, Mass.) at the Hospital, on May 16, following an operation. Miss Wilder was councilor of the Alumnae Association and was one of the most zealous and devoted members. She gave untiringly of her services, and by her wisdom, counsel and faithful attendance added strength to her Association. She had been industrial nurse at the Arnold Print Works in North Adams for the past ten years and was employed there at the time of her death. Services held at the Baptist Church were largely attended, not only by the Alumnae Association and the employees of the Arnold Print Works, but also by her many friends who came to pay a last tribute to her who was not only a loyal and faithful nurse but a sincere and true friend.

*"To travel hopefully is a better thing than to arrive, and the true success is to labor."*

*Robert Louis Stevenson in "El Dorado".*

# About Books

**Tuberculosis and How To Combat It.** By Francis M. Pottenger, A.M., M.D., LL.D., F.A.C.P. Second edition. 275 pages. C. V. Mosby Company, St. Louis, Mo. Price, $2.

A PICTURESQUE figure in the tuberculosis field (now gone to his reward) frequently remarked that a patient's recovery from tuberculosis depends more upon what he has above the collar than below it. "Tuberculosis and How To Combat It" is evidence that Dr. Pottenger holds this opinion, although he expresses it in a more conventional way, as, "Intelligence is the most potent factor that can be directed against disease," "The best patient is the intelligent patient" and "I obtain the best results by making my patients intelligent upon the subject of tuberculosis." Dr. Pottenger makes it clear that he means intelligence and not merely education when he says: "A man may be intelligent from the general viewpoint, but he may use very poor judgment in his coöperation for cure."

The book is a collection of talks which the author has given to his patients from time to time, in an effort to make them intelligent upon the subject of tuberculosis. A statement in Chapter VIII might have served as the opening paragraph:

> There has been no single remedy found which will cure tuberculosis. Its healing is brought about by living a life so directed that the patient's resistance is kept high over a period of time sufficiently long to allow the process to heal.

It is this directed life which the book proceeds to describe.

This second edition is more effective than the first in emphasizing the importance of medical direction. While the physician has no specific remedy to offer, and is practically powerless without the coöperation of the patient, successful treatment is possible only under the direction of a physician skilled in interpreting the manifestations of the disease and in prescribing appropriate treatment. The accepted items in the treatment of tuberculosis, such as open air, rest, exercise, food, baths, climate, etc., are discussed, more from the standpoint of explanation than direction. Under each item it is clearly indicated that for each patient, medical direction must be based upon his individual condition.

While the information is up-to-date, no really new ideas are offered but many of the accepted rules are expressed very effectively.

Chapter VII, on "Early Tuberculosis," emphasizes the fact that what is called early tuberculosis is a sign that the patient's resistance has already been overcome and that the problem presented is not as simple as it is sometimes considered. Health workers speak glibly of the importance of discovering early tuberculosis without realizing that it must even then be treated as a serious disease.

The chapter on "Open Air" is especially good. Fresh air is another term very carelessly used. All health workers will profit by reading this chapter. The place of climate in

the treatment of tuberculosis is well stated. While the increasing number of sanatorium beds throughout the country give evidence that the rôle of climate is becoming generally understood, statistics from the southwest show that many are still seeking climate as a cure.

Great benefit would result from a general broadcast of Chapter XXXIV, entitled, "How Much Shall the Patient Know?" The policy of keeping from the patient the fact that he has tuberculosis is all too commonly followed. Probably all who have been in tuberculosis work for a long time agree that the chances for the patient and for his family are immeasurably better if he is told of his disease. The first knowledge is a shock, but in by far the greater majority of cases the patient rallies and begins a determined fight to master the disease.

The element of time in cure is very well presented and the chapter on "Occupation" is brief but effective. The final sentence is pertinent: "As many tuberculosis patients are killed outside working hours, as by the work they do."

To find a name for all those who work as nurses in sanatoria no doubt presents a problem, since they range from the graduate nurse to the ex-patient without previous nursing experience. However, the term "Trained Attendants," as used in Chapter XXXVIII seems a little awkward.

The book is addressed to patients and will serve as an effective supplement to the physicians' instructions. Physicians may find new ways of impressing patients with their part in the treatment of tuberculosis; nurses without tuberculosis experience will profit by this readable presentation of the subject; tuberculosis nurses may experience a sort of renewal of faith, being reminded that the theories underlying the accepted treatment of tuberculosis are sound and that if success is not as usual as the author's optimism implies, the fault is not in the theories.

No estimate can be made of the time and energy expended by physicians in bringing tuberculosis patients into line with the treatment and often by main force of will, holding them there. The tone of this book indicates that the author has been fortunate in establishing a friendly partnership with his patients.

ANNA M. DRAKE, R.N.

*Ohio.*

STORY OF MODERN PREVENTIVE MEDICINE. By Sir Arthur Newsholme, M.D. 295 pages. Williams and Wilkins Company, Baltimore. 1929.

READERS of the "Evolution of Preventive Medicine" will greet with interest this continuation in "Modern Preventive Medicine." The story proceeds from the earlier gropings of the pre-scientific age to the spectacular findings of the "golden age" of scientific medicine. It traces the development of knowledge as to the nature and causation of disease from vague and fragmentary ideas to the establishment of the germ theory, and the important discoveries in bacteriology which followed. A general discussion of bacteriology as related to immunity and diagnosis leads up to the story of the prevention of the various communicable diseases.

Part Two deals with the physical and social factors of health, such as air and ventilation, sunshine, housing conditions and general sanitation. Part Three reviews some of the physiological conditions of health, and recent progress in the prevention of the deficiency diseases. Throughout the

book many interesting graphs and tables are included.

The book is arranged in concise and readable form and contains a wealth of information which would ordinarily require the study of many different authorities. The very limitations prescribed by the author; namely, that it is elementary and preliminary to more detailed study, recommends it to the average reader. This book should take its place beside the previous volume in every training-school library.

HARRIET FROST, R.N.
*Philadelphia, Pa.*

ETHICS AND THE ART OF CONDUCT FOR NURSES. By Edward Francis Garesché, S.J., M.A., LL.B. W. B. Saunders Company, Philadelphia, 1929. Price, $2.50.

ONE of the problems that beset educators is to combine the good things that education gives with the preparation for life after school days are finished. We have the problem constantly discussed, we read of it in the many periodicals prepared for us monthly and in other forms of literature. Advice is coming from all sides, from philosophers, educators, business magnates, clergymen and others, yet it remains still the problem and the question we have to deal with is how to prepare our youth to face and handle the realities of life.

Teachers of students in our schools of nursing have been long clamoring for a tangible something that would help them in the teaching of ethics. They have asked for something concrete, a code, that might prescribe the fundamentals of ethical conduct. An attempt has been made to formulate a code of ethics for the nursing profession in the United States that will satisfy a profession that articulates with other professions and professional work in the many and various ways in which these contacts occur. The nursing profession is looking for an ethical basis which will accommodate itself to situations which constantly confront individuals and groups in the conduct of their daily work and duties. The elements of philosophy based upon Christian teaching may not be looked upon as out of place in the education of our students of nursing. The standards by which we still conventionally judge are standards which have been handed down to us by tradition and have stood the test of ages. No doubt youth in the days of Aristotle, Thomas Aquinas, nay, even in the time of our favorite of history, Catherine of Sienna, had much against them even as today, for youth has always been impetuous, foolhardy, seeking expression in one way or another, otherwise it would not be youth.

Father Garesché, in his presentation of "Ethics and the Art of Conduct" to the nursing profession, has endeavored to answer the question by pointing a way by which a concept of moral philosophy may be brought within the grasp of young students and in a way that will claim their thoughtful interest. The introductory note and preface explain the basis of his treatise which he divides into two distinct parts: Ethics and The Art of Conduct.

In the first part he describes the meaning of the science of ethics and shows its relation to the science of conduct. He does not say that a science of ethics is fixed by tradition but that, like all sciences, it is constantly developing. That "ethics makes use of history and experience as a guide, a helper to check up its conclusions and to show how they can be reduced to practice." The first division expands into twenty-three short chapters which deal philosophically with human actions, their end and

purpose; the meaning of good and evil; our duties towards God, ourselves and others; the natural law and how it is enforced. Happiness is not left out; an entire chapter is on this "Master Motive" and the ways in which happiness is sought, as also the difference between happiness and pleasure. This matter is covered in a most readable and interesting manner, broken up into short paragraphs with center headings which make it easily handled. It gives the core of philosophical thought and the principles of the science of ethics in a way every student may readily understand.

There are those who will not agree with the author on some of his statements in this part which conflict with so called "modern thought." He has given a fairly long chapter to a discussion on society, subdivided into origin and nature of the family, marriage, divorce, birth control. He handles this much discussed subject from the standpoint of the attitude and teaching of the Catholic church, which will no doubt be enlightening to those who are reading and hearing a code based on social convenience and economic necessity.

The moral law and the natural law are defined and discussed in a simple easy way that carries the reader from one paragraph to another with compelling interest and concludes with a chapter on "Civil Government and Civic Duties" followed briefly by a paragraph on the nurse's obligation as a citizen.

In the second part the author deals with conduct, "those principles of action given us by ethics," and enters intimately into the mainsprings of character. Respect for the rights of others; self-knowledge, self-control, patience, kindness, devotion to duty, the quality of loyalty, honor, discretion, reserve. Several chapters are devoted to the cultural aspect such as conversation, reading, personal refinement. "The nurse's voice" brings out comments on the influence of the human voice "the most perfect and beautiful of all musical instruments." Throughout this second part of the work the author constantly applies his theme to actual experiences and shows an unusual knowledge, on the part of a man and a priest, in characteristics of women and nurses. Evidently he has thought through his subject very carefully and deliberately before putting it on paper. He is not discouraging; in fact, in this part I believe a student or a graduate would feel that he places an ideal that is well within the attainment of every nurse. He is not pedantic or "preachy," but rather conversational, easy, and at the same time direct and forceful. Father Garesché apparently has a wide vision and ideals of high order for the profession; he probably sees wherein it often fails, and in his zeal for its good he has contributed what he hopes will help to remedy the deficiencies. In the hands of the sympathetic teacher this work should illuminate what has often been a dry subject and which has not always been given in the light of the present-day needs of young nurses.

A third part is added in which are given points for discussion and writing. One might feel tempted to assign the lesson on the questions before the reading is done, commencing at part three and then going over the reading matter which the questions will bring out. The reviewer of this work has read it carefully, page by page, and in some cases has re-read chapters, in order to gain an understanding of the author's ideas and the basis upon which he has built his theory. She finds it largely what we have been thinking and teaching in our classrooms and what countless nurses

have been living in their daily work, but what has not yet found expression in the way Father Gareschè places it in this publication. Whatever objections there may be to parts, these would surely be outweighed by its sincerity of purpose, its simplicity of expression and its good common sense.

ANNA C. JAMMÉ, R.N.

*California.*

FOODS OF THE FOREIGN-BORN IN RELATION TO HEALTH. By Bertha M. Wood. Second edition. Revised. 110 pages. M. Barrows and Company, Boston, 1929. Price, $1.25.

AT the request of dietitians and nurses in public health work who are interested in the foods of people of different nationalities, Miss Wood has brought out this second edition of her well known "Foods of the Foreign-Born" and has added an appendix in which the food values of the recipes are given.

Although Miss Wood in her preface to the second edition seems to imply that the book is primarily of interest to nurses in public health work, it should really be of great interest to all of those within and without the hospitals who deal with the foreign-born. Furthermore, it should have a place in the home kitchens of those folk who like to borrow ideas, such as recipes, from other lands.

## *Books Received*

PRACTICAL NURSING. An Elementary Condensed Textbook for Trained Attendants and for Use in Practical Home Nursing. By Louise Henderson, R.N. Second Edition, completely revised. 239 pages. Illustrated. The Macmillan Company, New York. 1929. Price, $2.

One of the notable features in the new edition of this standard text for trained attendants is the section on the care of the aged, a subject too long neglected by both nurses and attendants.

A DOCTOR'S LETTERS TO EXPECTANT PARENTS. By Frank Howard Richardson, M.D., F.A.C.P. 118 pages. Illustrated. *Children, The Parents' Magazine* and W. W. Norton & Company, Inc., New York. 1929. Price, $1.75.

INDIA IN 1927-28. By J. Coatman, Director of Public Information, Government of India. 461 pages. Illustrated. Central Publication Branch, Government of India, Calcutta. 1928. Price, Rs. 2-8, or 4s. 6d., or $1.50.

ANTE-NATAL CARE. By W. F. T. Haultain, M.B., and E. Chalmers Fahmy, M.B. 113 pages. William Wood & Company, New York. 1929. Price, $2.25.

TEACHING HOW TO GET AND USE HUMAN ENERGY. By Thomas D. Wood, M.D., and Marion O. Lerrigo, Ph.D. 128 pages. Public School Publishing Company, Bloomington, Illinois. 1928. Price, 75 cents.

DIFFICULT DAUGHTERS (AND SOME OF THEIR PROBLEMS). By Jessie March. 47 pages. John Bale, Sons & Danielsson, Ltd. London. 1929. Price, 6/.

# *Books You Will Enjoy*

ISABEL ELY LORD

*THE TWILIGHT OF THE AMERICAN MIND*, by Walter B. Pitkin (Simon and Schuster, $3) does not sound like a cheerful book, but it is well worth reading—even if you need a few grains of salt with it. The author is concerned with our "best minds"—how many we need, how many we are likely to have in the near future, and most important of all, what there will be for them to do. We may not belong to them but we all ought to be interested in them.

Edgar Altenburg's *How We Inherit* is an admirable example of the "popular" scientific book—easily understood by any intelligent person with some knowledge of modern science. It gives what we know now about heredity, and hints at what we may hope to know some day. (Holt, $3.)

*Nicolo Machiavelli, the Florentine*, is the most modernistic of modernistic biographies—full of racy description, slang of today, Shakespearian frankness, and vivid characterization. Giuseppe Prezzolini is the author; and the translator, who has done the work unusually well, is Ralph Roeder. The book is brief, and an interpretation rather than a history. (Brentano, $3.50.)

*Wings of Song*, by Dorothy Caruso and her sister Torrance Goddard, is not really a life of Caruso, but the picture of his personality as his wife knew and loved it—a pleasant book, with many amusing things in it. (Balch, $3.50.)

Sinclair Lewis has doubtless added another name to our common talk in *Dodsworth* (Harcourt). It is his best work yet, with all the keen analysis of *Main Street* and an added mellowness that is most welcome. The story is that of an American business man finding too late—perhaps—that he does not know how to use leisure, and of his married life with a "typical" selfish American wife, and its end.

*Peder Victorious* is O. E. Rölvaag's sequel to *Giants of the Earth*, and much less gripping than the earlier book. It is worth reading, though farther from the soil, but *Giants of the Earth* should be read first for enjoyment of the later volume. (Harper.)

For those who like historical novels, *The Cavalier of Tennessee*, by Meredith Nicholson (Bobbs-Merrill), can be heartily recommended. It is the story of Andrew Jackson, with Aaron Burr playing a part in it.

An excellent list of *Fifty Conspicuous Novels of the First Quarter of This Century* is issued by the Pratt Institute Free Library, Ryerson Street, Brooklyn, N. Y., and will be sent on receipt of five cents.

### *Some Good Old Detective and Mystery Tales*

Buchan, John. *Three Hostages*
Collins, Wilkie. *The Woman in White.*
Doyle, Conan. *A Study in Scarlet.*
Green, A. K. *The Leavenworth Case.*
Gaboriau, Emile. *File 113.*
Stevenson, R. L. *The Wrong Box.*
Trollope, Anthony. *The Bustee Diamonds*
Twain, Mark. *Pudd'nhead Wilson.*

# Official Directory

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**U. S. Public Health Service Nurse Corps.**—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

**Nursing Service, U. S. Veterans' Bureau.**—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

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